National Quality Forum

Moderator: Karen Johnson
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Female: Hello. Good afternoon, everyone. Thank you, again, for actively participating in the Cardiovascular Steering Committee.

Today, we'll just being an orientation of jus some of the things that are your roles and responsibilities as Steering Committee members. So before we get started, we just wanted to kind of do an introduction of the team here at NQF.

My name is (Inaudible) and I'm the project manager on this team.

(Vie LaWong): Hi, everyone. My name is (Vie LaWong). I'm the project analyst on the (inaudible).

Lindsey Tighe: Hi. I'm Lindsey Tighe. I'm the senior project manager for the cardiovascular project.

(Rachel Winkler): Hi. I'm (Rachel Winkler). I'm the senior director for this project.

Female: OK. So now, we've introduced ourselves, but we thought it would be a good idea just to kind of know who is on the line with us today. So if you can give us your name and your background and some of your expertise and what you look to contribute to the team.

Mary George, one of our co-chairs.

Mary George: Hi. Good afternoon. I'm Mary George and I'm the senior medical officer in the Division for Heart Disease and Stroke Prevention at CDC. I -- one of the

things that I work on as overseeing a quality improvement project for acute (stroketation).

So I've had experience in developing NQF endorsement measures for stroke. And the last time this cardiovascular committee was convened, I was also on that committee and very committed to the work that NQF does in improving quality and reviewing quality measures.

Female: OK. Thank you, (Mary). Dr. (Caci), one...

(Tom Caci): Yes, (Tom Caci). I'm a cardiologist up at (Hill Parkers) and medical director for Population Health, and you've read in the paper that says that if we're going to get value in health care, we have -- have to have measureable agreed upon goals, and that's what NQF does.

Female: Thank you, (Tom). (Sanal Gatibe)? OK. Carol Allred.

Carol Allred: Yes, this is (Carol). I am actually your heart patient on the panel. I had a heart attack, a massive heart attack, about 10 years ago. I have a defibrillator. I've been actively involved with Women Heart, the National Coalition for Women with Heart Disease. I just completed a 6-year term as Chairman of the Board of Directors.

So I'm happy to be immediate past president at this point. I did serve on the Cardiovascular Measures Committee a couple of years ago and I thoroughly enjoyed the work and I think it's very important to have the voice of the patient heard, too.

Female: Thank you, (Carol). Linda Briggs?

Linda Briggs: Hi. I'm Linda Briggs. I'm a nurse practitioner and I'm also faculty at the School of Nursing at George Washington University in D.C. I have basically been practicing within the area of cardiology and cardiac surgery for pretty much my whole career as a nurse and then as a nurse practitioner.

Certainly I've seen some of the measures that we're looking at used in the clinical setting and have been responsible for reporting some of them to the hospital level folks so that they can report them to CMS and so forth.

I'm very much looking forward to working with NQF. This is my first experience in doing this, but definitely agree that the work with NQF is very important and I would also say that I'm very pleased and happy that Carol Allred is here as a patient because as she said, the patient voice is very, very important.

As a family member of someone who passed away not from heart disease, but with a longstanding history of having heart problems from age 39 forward, I can certainly vouch for what affects heart disease has on the family of folks and the patients that have heart disease. Thank you.

Female: Great. Thank you, (Linda). Jeffrey Burton.

Jeffrey Burton: Yes. Hi. (Jeff Burton). I love for what (Linda) just said and yes, also my first time working with NQF. So very excited to be here. I'm a director of clinical services in the Office of Clinical Affairs (inaudible) Association.

I've experienced in the quality improvement and clinical measurement from a health plan perspective. I am from a physician organization perspective. I'm also a registered nurse. I worked in cardiovascular surgical ICU and general free and post-operative surgical care in some hospitals in Southeast Michigan.

I'd say my expertise is probably mainly in the quality improvement and the outpatient measures. So happy to be here.

Female: Thank you, Jeff. (Lynn) -- Leslie Cho?

Leslie Cho: Hi. It's Leslie Cho. I'm the section head for preventive cardiology and rehabilitation at Cleveland Clinic and I'm also the director of Women's Cardiovascular Center and an interventional cardiologist at the clinic.

I serve the American Heart Association Secondary Prevention Council and I've served on NQF before about 2 years ago, and I'm on the cost -- I don't know what this technical (inaudible) that I'm on.

Female: (Inaudible) Resources.

Leslie Cho: (Inaudible) NQF as well. It's my pleasure to serve on this committee again because I really like everyone else has just stated really believe in the importance of quality and outcome for patient care.

Female: Great. Thank you so much, (Leslie). Joseph Cleveland?

Joseph Cleveland: Hi. Good morning, everyone. (Joe Cleveland) here. I am a cardiac surgeon practicing cardiac surgeon on the faculty at the University of Colorado, Anschutz Medical Center, where I actually clinically here lead our heart transplant mechanical (surgatory) support division.

My interest in quality improvement goes back to my involvement with the Society of Thoracic Surgeons as one of our volunteers dating back to work with actually one of our quality measurement task forces that have worked through the process of developing measures and having NQF endorsed measures.

This is my first appointment though with NQF. I'm very excited to engage the process from, if you will, this side of things, and have been a member of the AMA PCPI as well for the last five years and as everyone has stated, obviously believe that measurement qualities is extraordinarily important if we're going to provide value for our patients.

And we'll enjoy working with everybody in this venture. Thank you.

Female: Thank you. We appreciate your involvement. (Michael Crouch)? OK. (Elizabeth Delong)?

Elizabeth Delong: Hi. Actually, I'm Liz and good morning, everyone. I'm also glad to be here. I am the chair of biostatistics and bioinformatics at Duke University and have

an interest in ensuring that measures are meaningful and are not so burdensome that they have an opposite effect from their intent.

I have served on the NQF committees before and I think it's a very worthwhile mission.

Female: Thank you, (Liz). Ted Gibbons?

Ted Gibbons: Good morning. Ted Gibbons. I'm the chief of cardiology at Harborview Medical Center at the University of Washington and I've served on NQF before in 2010, 2011 as the chair of the cardiovascular measures and then the steering committee of cardiovascular, which was a great experience.

I -- my experience in this arena has been for many years I was at the Virginia Mason Medical Center in Seattle, which is a large group practice, which was one of the originators of the IDO lean thinking in medicine and a Toyota production model.

I moved to the University of Washington about five years ago and my main interests are in heart failure and in quality improvement. I'm very much looking forward to working with the committee and seeing the transitions that have occurred over the last four years going from process to outcome measures and cost of resources a particular interest of mine as well. So (inaudible).

Female: Good. Thank you, (Ted). (Ellen Hodag)? OK. (Judd Hollander)? (Judd Hollander)?

(Judd Hollander): Yes. Hello. I am a professor and have run the Clinical Research Program in Emergency Medicine at the University of Pennsylvania. Largely, my research is cardiovascular diagnostics; although, some cardiovascular therapeutics as well, and I've also done a lot of work in the area of E.B. Crowding and impact both on the patient flowing through the E.B. and those being hospitalized.

So I've had a big interest in this area and I'm honored to be serving for the first time with NQF.

Female: Great. Glad to hear. (Thomas James).

(Thomas James): Hi. This is (Tom James). I'm the medical director for clinical policies for Ameri Health Caritas, which is a national Medicaid company. I also chair the NQF Health Plan Council. So I certainly have enjoyed my time working with NQF and representing a Medicaid health plan, then hope to bring the perspective of those kinds of vulnerable populations that have some other unique risks.

Female: Great. Thank you, (Tom): (George Felities)?

(George Felities): Hi, everybody. (George Felities) here. I'm the clinical director at the Boston Medical Center, Cardiovascular Section, and in that role, and also as chief quality officer, I spend a lot of time working on sort of many aspects and elements of improving quality and efficiency.

Most recently focused a lot on 3-day readmissions and improving transitions of care, mostly from the in-patient, the out-patient setting. Like others on the line, I have worked on the C.V. Measures Committee in the past with NQF and found it a really worthwhile endeavor and I learned a ton and had a great time doing it. So I'm really looking forward to this project as well.

And I too have a particular interest in making sure that whatever metrics are created and adopted are fair and equitable to patients being cared for at safety hospitals given the fact that the Boston City Hospital where I'm based is one of the major safety net hospitals in Boston.

Female: OK. Great. Thank you so much, (George). (Christine Stern)?

(Christine Sterns): Hi, there. I'm (Christine Sterns). I am with the New Jersey Business and Industry Association. We're a trade association of about -- businesses here in New Jersey. Most of them are small; although, we have all the big Fortune 500 large companies also who are members.

My folks' biggest concern is the cost of health insurance, so we spend a lot of time focusing on health care, on what folks are paying for their health

insurance, but then also what they're getting for their money. So quality is a big issue and how do we try to measure that.

Female: Great. Thank you, (Christine). (Henry Ting)?

(Henry Ting): Good morning, everyone. My name is (Henry Ting). I'm an interventional cardiologist at Mayo Clinic Rochester where it's negative 20. And I -- my scholarship interests include out (inaudible) research, dissemination and implementation research and shared decision-making.

My administrative role that Mayo Clinic elude being the director of our quality academy, as well as, associate theme for quality in our College of Medicine. My -- this is the first time I've served on an NQF committee and my service in other groups is included being on the American College of Cardiology and American Heart Association Task Force for Performance Measures, the ACC Quality Committee, the various CMS technical expert panels and episodes of care measure development groups, and Redding Groups are -- many of our clinical guidelines and cardiovascular diseases, as well as, participating or leading national quality initiatives including door to balloon, hospital to home, and our newest one which is survival after myocardial infarction.

So I look forward to learning the committee.

Female: Welcome, (Henry). Thank you. (Joel Mars)?

(Joel Mars): Good morning, all. This is (Joel Mars), a faculty member at the University of Colorado School of Pharmacy and then practice clinically here in Denver at our county health system -- Denver Health.

I practice primarily in primary and secondary prevention with patients definitely focused on transitional care pieces over the last years of my practice. And so I have a strong interest in definitely reassuring these metrics are equitable across, you know, safety nets to academic medical centers.

And so definitely a key interest there and this is my first time serving on a NQF committee.

Female: Well, welcome (Joel). (Christy Mitchell)?

(Christy Mitchell): Yes, good afternoon. My name is (Christy Mitchell) and I am a senior vice president at (Avaleer) Health and I oversee a team who's charge is really to help our clients use clinical data for strategic decision-making, and in this era, it's all sort of evolving around quality and quality measurement.

So my interest in quality is actually longstanding and the intersection with cardiovascular nearly 20 years, I spent 12 of those years working at the American College of Cardiology, really overseeing and sort of being in the presence of the evolution towards creating performance measures in the early 2000s.

And so it's really nice to see not only the med -- sort of the fruit of our labor in terms of developing those measures and getting them into practice and watching them be used by CMS and others, but to see them now come back around for review.

And so this is my first time, my first experience with NQF, and I look forward to the opportunity to working with each and every one of you.

Female: And we look forward to working with you, (Christy). Thank you. (Nicholas Rogario)?

(Nicholas Rogario): Yes, good afternoon, everyone. I'm (Nick Rogario) at Jefferson -- Thomas Jefferson University Hospital in Philadelphia. I am also an interventional cardiologist. I'm the director here of the Structural Heart Disease Program, so we're big into sort of taver and so on and so forth, but I've done a lot of work looking at outcomes with the NCDR, as well as, with the ACC on different cardiac measures.

This is my first time serving on an NQF forum and I think it's going to be very interesting and I look forward to working with everybody on upcoming year.

Female: Thank you, (Nicholas). (Jason Spengler)? OK. (Mark Valentine)?

(Mark Valentine): Good morning. This is (Mark Valentine) from -- I'm the president of the Heart Hospital Baylor Plano in the Heart Hospital Baylor Danton and also serve as the service line leader for the Baylor Scott and White Health Care System.

I've been a -- an executive in the cardiovascular field for about 23 years now and we're really looking at everything from a measurement outcomes scorecard in perspective, you know, looking at the whole lean components of the cardiovascular world and looking at the value equation, the cost quality equation from value.

And we want to be the leader in that space within the Baylor Scott and White and across the country.

Female: Thank you, (Mark). (Levin Vudavic)?

(Levin Vudavic): Good morning, everybody. I am an interventional cardiologist at the University of Illinois in Chicago and I'm also chief of cardiology at the Jesse Brown V.A. in Chicago. I am also been appointed as the next ACC governor for the V.A. from 2018.

So from my previous research working with the outcomes that get with the guidelines in the NISH Acute Program, my interest for NQF is to see how the large government organizations with the V.A. where I -- where I work half of the time and whereas the leadership roles may integrate well to continue improving the quality at the V.A.

I worked at the V.A.'s MAE Committee, which is a very unique committee which -- further interest in qualities where all our adverse (inaudible) comes at the V.A. where independently reviewed through a peer review system.

So this is probably an (inaudible) really looking forward to work with you and learn more how different systems integrate in improving quality.

Female: Thank you, (Levin), and we do appreciate your interest as well as your participation. Also, (Helen Helagast)? Are you there? OK. Is there anyone else who hasn't gotten a chance to speak or who is on the line?

Sana Al-Khatib: Yes, this is Sana Al-Khatib. I'm sorry. I was late joining.

Female: OK. Hi, Sana. If you can just give a brief introduction of yourself.

Sana Al-Khatib: Sure. Yes. No. Absolutely. Good afternoon, everyone. My name is Sana Al-Khatib. I'm an electro physiologist at Duke University where I've been for the last 20 years. I did all my training here and I'm very interested in quality improvement and performance measures and have had several experiences working with the Heart Rhythm Society chairing their Quality Improvement Group, and now their Measure Development Task Force, but also working with the ACC on NCDR projects.

So having done a lot of outcomes research on (inaudible) of ICDs and so on and so forth. So I'm very excited to be part of where this project -- I've really never worked with the NQF like on a committee, but I was the spokesperson for the Heart Rhythm Society.

Maybe a few years back now when they had a couple of measures to present to NQF, so I've had the privilege of interacting with a few people from NQF and I really look forward to working with everyone on this project.

Female: Thank you so much, Sana. Was there anyone else that we missed?

Female: Operator, are all lines open?

Operator: Yes, they are.

Female: Thank you.

Female: Thank you. OK. We will move forward with our agenda for today. So today, our agenda will entail just giving a background...

Male: Why can't you hear me?

Female: Hello?

(Michael Crouch): This is (Michael Crouch). Can you hear me now?

Female: Hi. Yes, hi, (Michael).

(Michael Crouch): Hi.

Female: If you can -- if you can give your brief introduction of yourself.

(Michael Crouch): Sure. Sorry to join late. (Michael Crouch). I'm an interventional family physician, aggressive prevention advocate. I'm a full-time faculty on the Family Medicine Residency Program in Sugarland, Texas. I was at Baylor for 18 years before that.

I'm the research director and the quality improvement program director and I started doing cardiovascular prevention research about 40 years ago in medical skill primarily focusing on cholesterol.

And my current research interests are in shared decision-making for statin therapy, served on a previous -- the previous round of NQF Cardiovascular Committee and (inaudible) in the practicality of the guideline implementation for primary care physicians.

Female: Thank you so much for that, (Michael). I think that's everyone. OK. We'll move forward with our agenda for today. As mentioned, we will be providing a background of NQF and this project, what our focus is for the cardiovascular project, an overview of our NQF criteria for measure evaluation, your role as the committee. We'll also provide you with a tutorial of how to access the page which you've all, I believe, received information for SharePoint, as well as, go over this measure evaluation process.

So our NQF body is really a private, non-profit voluntary consensus standard setting organization and it's governed by several different entities. Our three-part mission is ultimately to improve the quality of American health care, primarily building consensus that's on a national priorities and goals for performance improvement and working in partnerships to achieve them.

Secondly, endorsing these national consensus standards for measuring and publically recording our performance, and lastly, promoting the attainment of national goals through education and outreach programs.

So who uses NQF endorsed measures? To date, we have over 700 performance measures and maintaining these measures through periodic review is essential to providing a usable portfolio of measures that essentially both meets our vigorous measure evaluation criteria, as well as, ensure that the measures used for public reporting and pay-for performance initiatives are up-to-date, and reflective of the current evidence that are reliable and valid, useful for accountability and quality improvement, as well as, feasible.

So within our consensus development process, we have eight steps. Our first step was the call for nominations as you've all received, and that includes the process of convening a multi-stakeholder committee.

To date, we have 23 individuals on our committee for this project. Our second -- our second step is the call for consensus standards and this is the period in which developers are submitting information on the measures that they wish to review and be evaluated by this committee.

We also have the standards review process and this is the process that we are currently in as our staff are currently reviewing these measures and that'll be discussed further into this presentation. In this set, you as the committee members will really start to participate by actively engaging in, for example, today's orientation call, completing your preliminary evaluation of some of these measures, attending the work groups as assigned, as well as, attending the two-day in-person meeting.

And after the meeting, staff will prepare a draft report that summarizes your recommendations on these measures and it will be posting to our site for public and NQF member commenting. As we solicit multi-stakeholder input, we encourage the committee to also share the report with colleagues and invite them to submit their comments.

The committee will then meet to review the comments received and determine appropriate responses. This is then reviewed by the consensus standards approval committee and they will review your recommendations for approval or disapproval. Then it goes into the seventh step, which is the board of

director's ratification, which they will -- at recommendation, as well as, endorsement of measures.

And lastly, stakeholders have the opportunity to appeal this endorsement decision during our fields process.

So our measure evaluation criteria is summed into six sections. Really, it's -- the condition. So, for example, in this case, cardiovascular, but how is it important to the measure and how is it important through public reporting?

We really emphasize and look into the scientifically accessibility of the measured properties, its feasibility, as well as, the use and usability. And ultimately, harmonization in determining which ones are best in class.

This project will relate to the cardiovascular conditions that can be used for accountability and public reporting for all populations within various settings of care. Currently, we are in a two-phase project. Our first phase we will be addressing the topic areas of heart failure, PCI and cardiac rehabilitation.

And at this point, we have over 70 endorsed measures within this area. (Reba), did you want to add anything to that?

(Reba): Sure. I'd be happy to. Slides are really inadequate to describe the cardiovascular portfolio as -- when we mentioned we have more than 70 measures. It is one of the largest topic area portfolios that NQF has among those 700 measures.

The spectrum of topic areas within cardiovascular is really quite broad. It includes the ischemic heart disease, both the out-patient management, as well as, the acute events around AMI, as well as acute intervention such as PCI.

I will mention that cardiac surgery is not included. Otherwise, you'd be -- overwhelmed, and so cardiac surgery is in our surgery project, but, of course, there is a great deal of relationship with the topic areas in cardio (inaudible). So we do want to keep you abreast of what's happening with the surgery measures as well.

We do have measures around rehabilitation. We have measures for both in-patient and out-patient care, patients with heart failure. We have measures addressing rhythm disorders such as atria fibrillation and the use of an ICD, and we have measures for hypertension.

So very shortly, we'll be posting a list of the entire portfolio of cardiovascular measures that'll be available to you on SharePoint. As we mentioned, one of the -- or will mention one of the roles of this committee is to really oversee this entire portfolio.

We will be as a standing committee we will be coming back to you on a cyclic way to do portions of the measure review. We are not going to attempt to evaluate all 70 of them at once. I will mention that particular -- we have a fair number of measures in the portfolio that address blood pressure and lipids.

We are not going to be bringing those in for maintenance review until the developers have had the opportunity to respond and consider the newest guidelines for blood pressure and lipids. It will affect some of those measures and I think we're going to see some significant changes.

So those reviews are just delayed until they've had a chance to deal with that. So it's a big -- it's a big portfolio. So if you go to the next slide though, for our first cycle of review, the measures will be reviewing in April these 16 measures and you can see they stand the topic for a couple for AMI, some for heart failure, and a goodly group of measures around PCI.

We've had a significant number of new measures submitted, as well as, the measures that have been endorsed that are due for their periodic maintenance review. All of the measures, whether new or maintenance, will undergo the same review using the current criteria, which we'll discuss a little bit later.

One thing that's fun about this particular portfolio is the fact that in the area of cardiovascular, we've really seen some true measurement leadership with the development of significant number of outcome measures, as well as, composite measures that combine a lot of process and outcome measures together in a more summery measures.

So some of the challenging aspects of measures will need to be considered because we are seeing in this portfolio some of the more leading edge type measures compared to some of our other portfolios.

So this is the group we will be reviewing for our April meeting. All right. (Inaudible), back to you.

Female: Thank you, (Reba). And just to talk into timelines, these are the dates in which we're anticipating -- convening for work group calls, for our in-person meeting, just some of the highlighted timelines that we encourage you to take note of.

As time goes along, for example, within the work group calls, we'll definitely assign your work groups and you'll be alerted of what time and date are assigned for your group.

Lindsey Tighe: And this is Lindsey. We'll send out Outlook appointments for all of you for these dates so you'll have them in a multiple basis.

Female: Thanks, Lindsey. So what is the role of the standing committee? And we -- obviously, this is a smaller list, but we really bring together this group to really evaluate the measures in depth and make a recommendation to NQF membership for endorsement, and the membership will then vote on these measures.

So you're essentially acting as a proxy for the multi-stakeholder membership. We encourage to serve for two or three-year terms. You're working with our staff to achieve the goals of the project, which is essentially to evaluate these measures against our measure criteria.

Responding to some of the comments submitted during the review period, as well as, respond to any direction given from our (inaudible) committee.

Lindsey Tighe: And as a further comment, (inaudible) two-year or three-year terms, we are transitioning to standing committees at this point. We do convene ad hoc steering committees to address a topic area just for one cycle of review of measure.

Now, we're moving forward a standing committee, which will be established and really own the portfolio of measures and review all of the measures and just really come to understand for this part of the cardiovascular topic area.

And so as such, we're doing staggered two-year or three-year terms of this committee. Some of you will serve two-year terms and some will serve three only so that as we get this off the ground we're not receding the entire committee and one point in time.

So we'll be randomly assigning you to either a two-year or three-year term at the in-person meeting in April. If you have any concerns about serving either two-year or three-year term, please let us know. But otherwise, it will just be a random assignment.

Female: Thank you. As mentioned, your role is essentially to review all measures and that's including in the portfolio. So evaluating the new measures, the endorsed measures for maintenance and identifying any gaps.

We could -- as well as consider measures that may arise including ad hoc reviews. We also encourage to make any recommendations to the NQF membership for endorsement and as well oversee the portfolio of measures.

So the role of the standing committee co-chairs; so that is Dr. (Caci) and Dr. (George). Your roles essentially will be to facilitate the standing committee meetings, particularly the April meetings, the in-person, working with our staff to achieve the goals of the project as well, but also assisting in anticipating questions and identifying any additional information that may be of use to the standing committee.

Keep the steering committee on-track to meet the goals of the project without hindering critical discussion or input, represent the standing committee at the (SSAC) meetings, as well as, participate as a standing committee member.

So our role here at NQF is really to help facilitate this process. So we'll be organizing these meetings and conference calls as you've been receiving emails from myself and (Vie) throughout this process.

And really guiding you through the steps of the CDP process and advising any of our policies or procedures. We always encourage if you have any questions with anything to definitely follow-up with us and reviewing the measure submission and prepare materials for the committee review.

So at this time, we're definitely looking at (inaudible) measures that have been submitted and we will be providing that to you for further evaluation. Additionally, to draft and edit these reports for your review and ensuring communication among all projects, participation is encouraged.

Lastly, we help to facilitate any necessary communication between any of our projects because I do know we have some measures within our portfolio that kind of plays into some of our other projects, so we're helping to facilitate that discussion is one of our roles.

Additionally, we respond to any of the member or public crew about this project. I know, for example, I received a call about the new JNCA guidelines. So things like that is what we kind of respond to.

We maintain all of the documentation for the project activities and posting this information to (inaudible) NQF website, but also to your SharePoint page, and we are currently and actively working with many of the measure developers to provide any necessary information as it relates to their measures and any communication that they deem fit to be submitted when their committee is evaluating their measures for endorsement.

And lastly, the project staff works with communications department to publish this final report. So now, I'll turn it over to my college, (Vie), and she will give you a tutorial on how to navigate through SharePoint. We stress that if you have any questions, please do let us know because we would like to make this a smooth process as possible for you as you begin to go into the website and reevaluate some of these measures.

(Vie LaWong): And on that note, does anyone have any questions on the material we've already covered? OK. Great. Hi, everyone. This is (Vie). I am going to do a quick SharePoint tutorial with you all. By now, you should have already

received an email from nominations with your SharePoint username and password information, along with a -- the link to the SharePoint page.

You can also access the link via PowerPoint presentation as we do provide it for you here. So we want you to be familiarized with the SharePoint page, and so I will be doing a clean share right now with you all just so we can walk through some steps.

This -- can everyone see the SharePoint page right now?

Female: Yes, we can.

Male: Yes. Yes.

(Vie LaWong): OK. Great. All right. So as you can see, SharePoint has a few different categories with it. I'm just going to click on the (inaudible) homepage right now and this is what your SharePoint should look like once you log in.

Within the committee homepage, you will see -- this is where you will see all of your documents, so we have the general documents, which include anything related to the standing committee and the committee guide book, along with measure evaluation criteria information for you all.

This also includes measure document steps. Right now, we only have one posted, which is measure 0521, but more will be posted shortly. Along with that, there is also information about any of the meeting documents.

You can see here we have two main documents already uploaded (inaudible) agenda and the flags for your review. Now, status is where you go for all of your jump documentations pertaining to our project.

We also included a committee calendar link. This includes all of the meetings and information such as (fallon) and webinar length to our meetings. And committee length, which includes National Quality Forum homepage and our project public page, along with the committee roster, all of your information up here including your emails in case you want to connect with one another during your workshop, and as always, staff contact information is here for you.

We have our phone numbers and our emails ready for you at any time. And in addition to that, we have a survey link and we can talk more about this as the project progresses. I just wanted to make sure that everyone knows where everything is.

I just want to make a note of one thing, in SharePoint sometimes when you go to your committee's homepage, document staff might not appear, as you can see here. There's the plus and the minus signs. Sometimes you'll just need the -- and it doesn't show you additional documents attached. All you have to do is just click the signs and more documents will show if there are any.

As always, I'm here. So if you have any questions or concerns, please feel free to shoot me an email or (inaudible).

Female: Are there any questions?

(Vie LaWong): Do you have any questions pertaining to SharePoint for the time being? Did everyone receive their username and password?

Female: Yes.

Female 4: Yes, thank you.

(Vie LaWong): OK. We would very much encourage you if you haven't -- if you haven't already tried to log in, please do so today and email us if you're having any problems. It is something that some computers have firewalls, some people just don't have the appropriate downloads, and maybe something we have to work with you on to get you access.

So the sooner we know that, the easier it is, and we won't have you getting behind once we have more information available for you.

(Tom James): I've got a question.

(Vie LaWong): Yes.

(Tom James): Yes, this is (Tom James). If we already have an NQF login, can we get to this SharePoint site from that or do we need to use that external link that you provided?

(Vie LaWong): You need to use the external link that was provided. Our SharePoint system is separate from our quality form data. We're at login at this point.

(Tom James): OK.

(Vie LaWong): And the link is also on the PowerPoint today for your briefing. Any other questions? OK.

Female: Thank you, (Vie).

(Vie LaWong): (Inaudible).

Female: OK. So we're going to turn it over to (Reba) and she'll give us a more in-depth analysis on our measure evaluation overview and how that works. (Reba)?

(Reba): Thanks, everybody. I recognize a lot of names on this roster of folks I've worked with in prior projects and it's great to have you all back and the opportunity to work with you again. Today, all I want to do is provide a really high-level view of NQF evaluation criteria.

NQF endorses measures for accountability applications such as public reporting, various payment incentive programs, perhaps accreditation, and other accountability applications where information about your performance is sent outside to others, as well as, for quality improvement, which is certainly the bottom line name of the game.

In order to do that, NQF uses standardized evaluation criteria, and the reason we do that is because it really provides a general rules of the road for everybody. Measure developers know what to expect if they submit their measures for evaluation, and also, external end users know how this -- how the measures have been evaluated, and if they are endorsed by NQF, they

know that they've met a certain standard or a certain level of -- against all of our criteria.

And so it is important that we remain true to the use of the criteria because that's what's viewed as really one of the values of the NQF endorsement process. Now, it's true, the criteria have evolved over time in response to stakeholder feedback.

The quality measurement enterprise has grown and evolved tremendously over the last decade or so. We've had greater experience, we've got lessons learned, they're expanding demands for measures, there's a growing ability and capability for measurement, moves towards outcomes, moves towards composite measures, moves towards patient reported outcome measures, and all sorts of new types of measurement is -- are really coming online.

And so our evaluation criteria is constantly evolving. So I think if you've worked with us in the past, you may find that while they haven't changed dramatically in the overall, there may be some changes in the nuances.

And we also have developed some new tools to help steering committee members use the criteria to foster a relatively standardized approach so that measure developers can be assured that there's a consistency among various standing committees.

So the first thing I'd like to do though is I'd like -- (Vie), can you bring up the steering committee guidebook, please? The steering committee guidebook is one of the newest creations that we've created for steering committees, the standing committees, and this guidebook is intended to really be your primary reference and resource while you're serving on a standing committee.

It talks about NQF. It talks about measurement. It talks about -- oh, good, the title page is up. And you'll see in the table of contents we talk a bit about NQF. We talk about sort of the evolving landscape, as I've mentioned, the things that are really starting to come online as of interest and needs in the stakeholder community.

Some of you have a greater or lesser experience with measurement or have more technical expertise than others, and so we've tried to put information in this guidebook that we'll provide information for all levels.

And so we have a section on the ABCs of measurement that helps describe some of the basic considerations and issues. You also -- you'll see section 4, really goes through the detailed steps of the process by which NQF endorses measures, and so those details are laid out for you, and then the measure evaluation process and exactly what we expect from the standing committee, as well as, the actual nuts and bolts of the process with a great deal of detail.

So you'll find as we continue to communicate with you on -- as we go through this process, we will be referring you to this committee guidebook. We do updated regularly as things within NQF change, but really, we see this as sort of the one place where all the information pertaining to the endorsement process, NQF's policies, NQF's approach are -- reside here.

And if we keep -- and we're keeping this up-to-date so that the newest version is always -- represents what's currently happening at NQF. The section I'd like to point you to for our discussion on measure evaluation criteria is section 6, and if they can click on this, all of the table of contents actually is linked to the sections within the criteria or within the document.

And this is a section that's, I think, about 25 pages and (Vie), if you'll just gently kind of scroll through, what you'll see is in this, we've attempted to provide you with a lot of the background and the rationale for the criteria.

We use these co-lab boxes to try and summarize the most important pieces. And so I really would ask you that after we do -- go through just a very high level review today that you take the time to read this section, and that will be a really important reference for your understanding of what we expect you to do in terms of evaluating the measures.

We use a lot of internal links in these documents, and so if you're in the middle of it like this, I'll ask (Vie) to hit the ALT and the left arrow key, and that takes us back to the table of contents. You can navigate around these documents.

So as I go through this overview, I'm going to reference pages and we're talking about the pages in this committee guidebook where you can see additional information beyond what I'm going to be discussing today.

So (Vie), if you could bring the slides back up, we'll go through those. Anybody have any questions before we get started on some of the details of the evaluation criteria? Next slide. All right. Where's the criteria? Fire one (inaudible). (Vie), next slide. Thank you. OK.

This is the description of sort of the overview at 50,000 feet, if you will, into a endorsement criteria outlined in more detail on page 36 of the guide -- o f 32 of the guidebook, but these big categories of criteria really haven't changed in all of NQF existence, but how we apply them and maybe what we mean by them in some of the sub-criteria have become more focused and more responsive to the needs of the measurement enterprise, but there is hierarchy and we're going to talk about the individual parts in a little bit more detail.

But the hierarchy starts with the first criterion, which is importance to measure and report, and I just want to point out that this is not the same as important. Everything we do in health care is important, but not everything we do needs to be measured.

And so the importance criterion really are way of trying to identify those areas that most benefit from measurement to drive improvements in performance. So we're going to talk a little bit more about the sub-criteria in important in a moment.

This is a must-have criteria and if you as a standing committee does not feel that it meets the criteria, we're -- that's the end of the evaluation. The next step -- next criterion is around the science of the actual measure itself, the reliability and validity of this measure with the specifications provided, how well does it perform as a measure for providing information of quality, and we'll talk a little bit more.

This is also a must-have criteria. The other two are -- next one is feasibility and we really want to have an understanding how it -- when this measure is

put into play in the field, what type of costs or burden or difficulties may be encountered so that it can be weighed in the evaluation of this measure, and the recommendation you might make.

It is not a must-have criteria, but it's certainly important information to evaluate and consider. The last one is usability and use and we really -- and this is truly a result of stakeholder feedback is really we need to have a good understanding of how the measure is going to be useful in providing information, making decisions, how it will be effective in accountability applications.

And so you'll see that the sub-criteria address those issues. Sort of the fifth criteria, if you will, is a need to look at related measures or even competing measures. Certainly cardiovascular we see a lot of measures that are constructed very similarly, but just enough different to be very annoying to keep in the field.

So we really have put a high priority on harmonization of measures so that we can try and reduce that little bit of difference that truly is problematic for folks trying to implement or for folks being measured in the field. And so that will be our last -- our final criterion.

So those are the big five, but each one has details underlying it that we want to talk about in a little more detail. So criterion one, importance to measure and report, and as I mentioned, this is isn't important. It's not the same thing at all.

It is defined by three sub criteria. The first one is the evidence for the measured focus, and what we're talking about is what's the measure all about, you know, what is it? A process of care? Is it intermediate clinical outcome? Is it an outcome measure?

And so we want to know about the evidence around that process of care and specifically relationship to patient outcomes, how will this process -- how does this process of care impact the patient?

And second criteria is opportunity for improvement. Really want to understand what the quality problem is around this particular topic area. Is it

a process of care? Is it something that's not being done? Or, you know, is there high variation around it? But, you know, in general, measures that already are performing very, very well and processes of care that are done uniformly, don't make good accountability performance measures because everybody's got an A -- will get an A. That is not going to drive additional improvement.

So we really do look for measures where there isn't ongoing opportunity for improvement so that we can get some improvement in performance for the cost of our measurement efforts. The third one is high priority and this in general reflects the nature of the condition that's being measured whether it's high prevalence, high morbidity mortality, perhaps high cost, and frankly, most of the conditions in cardiovascular will readily meet this sub-criterion.

There is one other sub-criterion that only applies to composite measures and that is really understanding why different components were put together in a composite, and so the construct and rationale of the composite measures is going to be an important part of understanding the importance of this measure.

So these are the three sub-criteria for measures. It's four if it's a composite measure around the criteria of importance to measure and report. So the evidence is the area, I think, that becomes the most complicated to evaluate. The evidence criteria depends on the type of measure.

For outcome measures, as I mentioned, our focus is what is the relationship to patient outcome, you know? What's the impact on the patient? Well, outcome measures actually measure the impact of on the patient and so there is a real push and drive towards more and more outcome measures and we are seeing that particularly in this area of cardiovascular.

And so really, the import -- the evidence for outcome measures is really not very -- a great deal required. It's really can we understand that how that outcome is influenced by health care processes or structures.

So it's really a very straight-forward and simple rationale for the evidence and a requirement for a pure outcome measure; however, process and intermediate outcome measures are different because we really want to understand if this

process of care truly is -- has a high likelihood of impacting the patient improving performance will improve patient outcomes and we want to see that close evidence-based relationship between processes and intermediate outcomes of care and true patient outcomes.

And so what we are looking for is the body of evidence, and we're talking about the (empiric) studies that constitute not just selected studies, but the entire body to really try and minimize the bias about what we know of the evidence for any particular process or intermediate outcome of care.

And so we really are trying to implement the recommendations from the institute of medicine around systematic reviews and use of systematic reviews for clinical practice guidelines. And so optimally, we really would like to see the results of the systematic review around the process of care or the intermediate outcome with the grading of evidence and the summary of the quantity of studies, the quality of those studies, and the consistency of their results and any assessment of biases that are identified during the course of a good systematic review.

So this is what we're -- we -- we're asking for. We realize that we're kind of in a transition zone where there aren't systematic reviews for every topic area. We know that the folks developing clinical practice guidelines are still trying to transition to doing systematic reviews and grading of the evidence, and so it's highly variable at this stage.

Though, in general, we find that most of the measures do rely on clinical practice guidelines for their evidence base. And so we will be looking at the grading of those clinical practice guidelines and what the grades mean for the different organizations that are writing the guidelines.

So the evidence criteria, again, I think is sometimes maybe a little overwhelming for folks, so one of the things that we have done to try and help steering committees both through the evidence criteria with the information on a measure is we've created an algorithm and (Vie), if you go to the next slide, this algorithm -- we're only showing a portion of it in this slide -- gives (inaudible) in your guidebook on page 37, it's also in several of our

documents that talk about the criteria, but what this does is meant to help you really ask the various questions and lead you to a decision point.

And so, for instance, this one on evidence, the first box asks you is it an outcome or is it a process measure? If it's an outcome measure, it'll take you over to box 2 and just ask do you agree as a committee that the relationship between the measure, between the outcome and at least some process of care of activity in the health care arena will be supported by the rationale?

And so that's your options for rating are given. Most measures, I mean, we have served a divided group. We've got a goodly number of outcome measures, but for the measures that are process measures and you'll -- to box -- and we'll ask question -- the algorithm asks questions about is it based on the systematic review and then box 4 asks well, if you have a systematic review, do you have information on the quantity, quality and consistency of the evidence such as from a formal systematic review?

And if that's the case, then it takes you over to box 5 where you look at that information and look at how it should be rated high, moderate or low against that criteria. So this algorithm is -- was designed to help steering committees.

We put it out for public comment last summer. We got good feedback, made some tweaks; measured developers particularly felt that this would be helpful to steering -- to standing committees in the consistency of ratings among measures and among the various committees.

And so you're one of the first committees to be using this, so we really are looking for your feedback to see if indeed this is helpful for you and whether how we might make it even more helpful going forward.

So that's the information around that first criteria around evidence and the tools. I really strongly recommend that you read the background information that we've provided in the guidebook. It talks a lot about the rationale for the various -- for the evidence for the various types of measures.

With that, I'll just pause for a minute and see does anybody have any questions about that first criteria and particularly around evaluating evidence?

OK. I am -- my goal here is to really introduce you to these things and hope that in the coming days and weeks you'll explore more with the resources we've provided for you on SharePoint, specifically the committee guidebook.

So let's move on to the next criterion, which is reliability and validity to scientific acceptability of measured properties, and this is where we get into some of the nitty-gritty details of how does this specific measure with these specifications, this data source, how does it perform? How are the results that are generated by this measure, how reliable, how valid are they?

Some of you on the committee have tremendous experience with methodologies and measure testing and we will certainly be relying on you. We are trying to provide guidance for the entire committee and we realize that not all of you have the technical background, and we will provide as much support as we possibly can to help you work through this criteria.

The front -- the two of them work together, but we do look at reliability and validity separately. Reliability is about consistency and precision of measurement. Two real important elements of it are first the specifications. We really need your good eyes to take a look how this measure is specified.

Are all the definitions that are needed to make it clear in -- and standardized present, do you understand it so that when this measure rolls out into the field is everybody going to implement it the same way?

So precision and specifications are really sort of a necessary prerequisite for a reliable measure. The other is we do require testing for reliability either at the level of the data elements or at the level of the measured score.

We also look at validity and several aspects for potential threats to validity. Again, specifications are important to consider with the evidence you've just reviewed. If you just reviewed the evidence and said yes, the evidence's strong, but the measure is measuring something different, that disconnect is important to identify because your evidence of criteria won't apply.

So we really want to see if the measure really reflects the evidence. We ask for validity testing of either the data elements or measure score. We really

want to look at exclusions, how justified they are. Again, this should relate to the evidence.

Whether there's a need for risk adjustment, typically process measures don't have much risk adjustment, but the outcome measures, we're going to see definitely do. And so risk adjustment can be a relatively complex enterprise, and so we will need to look at the risk adjustment methodologies and how well that is working to make these measures valid in the judgments that can be made from the measure results.

We also are -- it's important to know whether the measure can generate the type of information that allows us to make -- identify differences in performance. I mean, that is one of the fundamental goals of these measures for accountability purposes is to be able to make comparisons among different providers.

And so we want to know can this measure do that? Also, whether if the measure is specified for different data sources, are they comparable, are the methodologies are the same, we are starting to see measures submitted as e-measures, true e-measures, and in fact, you do have a measure submitted that is the 30-day AMI mortality measure submitted as an e-measure.

And so that's going to add even another twist as we're kind of leading the way in measurement in this cardiovascular portfolio.

So next slide, (Vie), will kind of just give a general sense of a graphic of reliability and validity. I think it's fairly self-explanatory. We really want our measures to be -- hit the target like on the far right that are both reliable and valid rather than the other two options.

So next slide. As I mentioned, we do require that measures are tested. We -- in that testing, we are talking about an empirical analysis to demonstrate the reliability and validity of the measure. We want to know about potential threats to validity, about the conclusions that can be made and all the other things we just talked about.

So the key points for this are listed on page 46 in the guidebook, and again, I refer you to them. Next, specifically for reliability, and again, pages 46, 47, goes into this in greater detail, we mentioned -- stay where you are; don't move. Slide back. Thank you.

We talked about the fact that we are -- testing can be done at the level of the measure score or testing at the data element level. So reliability of the measure score refers to looking at the actual result of the measurement, what was the performance result.

And we need to know how reliable is that result if different folks are implementing the measure, over time is it reliable and stable, and so the measure score is really the information that's important when it comes to using these measures in the field.

And so that is really sort of giving us a higher priority or, if you will, a potential for a higher rating if you -- if the testing has been at the level of the measure score. Some of the most typical ways of measuring for liability to measure score are statistical analyses of a variation like a signal to noise analysis.

There are others we do not prescribe what type of testing. So we expect the developer to explain what they did, why they did it, how they did it and what they found out, as well as, their interpretation of the results.

So like I say, measure score, but we also accept reliability testing at the level of the data elements, and this is the reproducibility at the individual data pieces rather than the calculated measure score.

And so the most commonly that this is tested is frequently inheritor reliability, comparing, say, chart abstraction with two different abstractors and do they end up abstracting the same data elements in the same way, and that kind of testing can be done with percent agreement, capa scores, et cetera, and appropriate statistical analysis.

So we will be asking you to think about the testing that's done whether it's an appropriate method, and whether the sample that they tested it on really is going to -- is a good representation for using this measure more broadly.

Now, I know that that may seem an overwhelming kind of thing and if some of you feel that you're really not that well versed in methodology and how would you know whether a testing method is appropriate, we understand that.

And actually, the staff review that we'll show you that we're going to provide to you to assist you will help bring some of this information so that we aren't totally relying on your guessing, if you will.

Some of you, of course, have a wide experience with methodology and we're going to be relying on you to help with that as well. So don't get overly intimidated. Use the tools we've provided to help and if -- and always, always, always get in touch with us. We'll be happy to help you as well.

Now, for reliability testing, again, we've provided an algorithm. Again, a new algorithm, again, to help the committees really look at measures and, again, this is just a portion. A full algorithm is in the guidebook. It's also in our other guidance documents, but the first question is about the precision of the specifications.

And if you don't feel that it's precisely specified, it's ambiguous, the definitions are not there, appropriate codes are not there, whatever, then you would rate it low. If indeed you're OK with the specs, then we go into questions and hopefully this will help you with your thinking process.

Was empirical testing conducted using statistical tests with the measure as specified? We're finding as we're working more and more with developers that this is more and more of answers. Yes. And so the question is was it tested at the level of the measure score, which takes you down to box 4 and then assessment of the methods. And then over in box 6, the results. So then what happened?

So these kinds of algorithms are meant to help you and, again, we hope that you'll give us feedback to tell us how well they really have been as a tool and an aid for your evaluation.

Again, this is meant to be a high level overview during our tutorial calls. We can go into this in a lot more detail, but I'd just stop for a second. Does anybody have any burning questions at the moment?

Sana Al-Khatib: I have just a quick question. This is Sana Al-Khatib...

(Reba): Sure, Sana.

Sana Al-Khatib: ... about the risk adjustment piece because, I mean, I've seen some measures where the developers may decide to do stratification rather than risk adjustment. I just want to hear if -- NQF if you -- you know, if you accept that methodology.

And the next question about risk adjustment I'm sure you will be wanting us to provide input on what's clinically meaningful and relevant, but I also see sometimes people like adjusted for 70 different variables and so it becomes very burdensome for people to apply that methodology.

So how does NQF look at that?

(Reba): Yes. Well, we'll talk about it and it will become very important. And you've raised some very specific considerations for the committee to deliberate when we look at some of these risk adjusted outcome measures.

Again, we look to you and the experts on the committee, and again, I think there are several of you who are very well steeped in this. But in terms of type of risk adjustment, it -- we do not prescribe, and so if stratification is an appropriate method of risk adjustment, that would be fine, but again, they have to, one, explain it, make the case for it, justify it, and you all have to buy it.

And so it's a matter of explaining and making the case and then the committee, you know, as an audience of multi-stakeholder audience saying, oh, you know, I'm not so sure or yes, that makes sense.

Certainly those of you who are clinicians, your clinical expertise in terms of the clinical factors will be an important consideration. I think you've also raised some of the issues around looking at measures, around feasibility and usability perhaps.

It may make the measure more valid to add lots and lots of risk factors that really don't change the outcome very much, but that really may significantly impact the feasibility and usability of the measure.

And so I do encourage you to raise these issues for discussion among yourselves so that you can factor them in into your evaluation as a whole.

Sana Al-Khatib: Great. Thank you.

(Reba): OK. Anything else on that? Because I'm going to quickly move to validity. And just a couple of high points on validity -- again, is refer you to the guidebook for more detail -- is in this particular case why we would really love and prefer empiric testing of validity, either at the level of the measure score, which is sort of where it's at, and that's around sort of making a hypothesis of relationships of this measure to other concepts, other measures, to really determine how good the conclusions you can make about quality are from these measure results.

We accepted element testing particularly if they're looking at the data element used in the measure compared to the gold standard or the authoritative source, which is usually the patient medical record.

If indeed that is what they've done as a validity assessment at the level of the data element, it will meet the criteria for both reliability and validity, but only at the level of the data element, not the entire measure score.

But, you know, the world is still evolving in terms of measure development and empiric testing of validity is not that easy to come by. We are seeing

more and more of it, but we do accept an assessment of face validity, which is a subjective determination by their -- by some experts that the developers have systematically assessed to determine whether the measure appears to reflect quality of care.

And so we do look for a systematic assessment. We would prefer if the group they asked was not the group that was developing the measure and we're seeing a bit of some and a bit of the other.

So face validity is acceptable, but the highest rating measure relying solely on face validity could have as a moderate rating. So you'll see this as you go through the algorithm and the description in the guidebook about validity.

So if we go to the next slide, guess what? Another algorithm. We've got one for you. So you can follow this along to help get a sense of how your thought processes could be organized around understanding the information provided around validity. OK.

So we'll move on to the next slide where we really also want to think about a threats to validity, whether they're conceptual about how the measure is constructed versus the evidence, whether, you know -- it's hard to be a valid measure if it's not -- if it didn't meet the reliability testing, but also exclusions, differences, how the scores are generated with data sources, and then how missing data is handled.

Missing data sometimes the patient's are excluded. I wonder if we are excluding our quality problems. So again, we really want to take a look at those potential threats to validity.

My experiences that these are areas that committees naturally talk about and naturally focus on and that's what makes your evaluation so meaningful. All right. Next slide, please. Excuse me.

The last one we talked about was feasibility and this was the extent to which collecting the data, crunching the data, reporting the data is costly and burdensome. I mean, every bit of measurement costs somebody something somewhere.

And so we really have to balance the relative value of the information produced versus the cost of getting that information. And so we really want to understand that potential issues around feasibility, around is this data that's generated during care process, such as within H.R. perhaps, or someone in addition having to go extract data.

Is it in electronic sources? Hopefully, electronic sources are becoming more and more utilized such that data management is much more -- much easier and less costly. And demonstration that the data collection strategy intended by the developer can actually be implemented and hopefully that can be determined during testing, but if the testing sample is really quite small and specific to a very narrow group is -- you may have some concerns about how widespread it will be able to be implemented.

And so feasibility is not absolutely required as a much pass, but it's certainly a very important topic and committees do spend a great deal of their discussion thinking about particularly new measures, how they're going to fair when they're implemented in the field.

Certainly for measures undergoing maintenance, we really want to ask about what their current uses are and what we've learned from uses particularly around any problems with being able to implement measures.

So that's feasibility. Usability is the last criteria -- next slide -- and so we want to know about, you know, what's this measure doing. For maintenance measures in particular, we really want to know what the experience is.

We want to know that it is used in accountability applications and so that's what our focus is. We want to know if it's driving improvement, what's the experience, what's -- what are the results over time?

And again, we're weighing the benefits versus the harms or unintended consequences perhaps or just costs, and the fact that we're all about transparency and the purpose of measurement is to provide information to as wide of audience as possible and is that happening.

For new measures, we won't have a lot of data to go on, but we certainly want to talk about what the intention and what the plans of the measure developer are, why did you develop this measure, where do you intend to use it, what do you hope it to accomplish, and so that's the use and usability criteria.

Again, not absolutely must pass, but certainly an important aspect and we find that in our comments after steering committees, standing committees have made recommendations, we certainly see a lot of comments around use and usability from stakeholders in the field. So it is an important criteria to think about.

And so our last of the big criteria are the relating and competing measures. And so we really do look at measures that measure similar things. We have an algorithm to determine measures that may -- that are just related versus those that are head-to-head competing.

It causes a lot of noise in the measurement world to have a lot of very similar measures, to have, you know, two measures to do the same thing. Some people use one, some use the other. You've lost your opportunity for comparability, particularly providers that are asked to provide measurement information from multiple entities, the payers, the creditors, whomever, and they all want slightly different information.

That's incredibly inefficient, it's incredibly costly, and there's really no purpose in that. So we really are trying to understand relating and competing measures, foster alignment, what we call harmonization, the specifications, really don't require reduplication and different data collection efforts in the field.

So a challenging criteria? Absolutely. But nonetheless a very important one, you know, from the stakeholder perspective out there. So those are the high level review of our criteria. I really do encourage you to read more about it. You'll get more insights into the criteria and how they have become into being by reading the section in the guidebook, some of the nuances around the criteria, but we know that it's a complex task.

And so one of the nice things and the benefits we see with the standing committee is you're going to gain experience. You're going to learn these criteria as well as anybody, and after you've had a -- the first go, the second one will be easier and the third one will be even easier and they're -- learned that you will build on and I think that will be more efficient and -- for everyone.

So does anybody have any questions right now before I move into talking about the kind of tools in the way we're going to try and help you with your measure evaluation process?

(Henry Ting): It's (Henry Ting). I have a quick question. You may elect not to answer this right now, but why is it that measure three and four, that of feasibility and usability, are not must-haves particularly with some of these then (inaudible) measures are for accountability and payment?

And the second question would be for harmonization, it seems like it's almost, like, it -- that a passes is also needed that has the same depth and detail to sunset measures as -- like for putting the expert resources into approved measures?

(Reba): Right. Well, OK. Your second question is your evaluation particularly of maintenance measures may find that those measures no longer meet the criteria and you will recommend that they do not continue being endorsed.

So that is our sunset process. It's one in the same. OK? So the question about usability and feasibility, why they must pass, and, you know, I know when we were -- when we worked on all these criteria with multi-stakeholder groups, you know, we do have that as part of the feedback.

I think there is a sense around feasibility that having measures that are stretched, the -- maybe not -- that may not be feasible immediately, but if everybody knows there's an expectation, they need to move in that direction, that data sources and methodologies can be focused on, you know, pushing us along so that what may seem not so feasible today may very readily be feasible in the future.

And so that tends to be the basic philosophy around feasibility and why it's not an absolute must pass, but certainly feasibility concerns have caused measures not to be endorsed. Absolutely.

Any other questions like that? All right. So the last thing I'd like to do is talk about how the information is being presented to you. And what we're doing -- and this is new for anybody who worked with us in the past is we are compiling the documents that you will need to review hopefully in a way that particularly helps you pull together a whole variety of sources of information.

What I'm asking (Vie) to bring up is an example of what you're going to find on SharePoint. If you go in right now, you're going to see measure 521 and she's going to bring that up. And what I'd like to show you is what we've done in this document to help you, and again, we're trying this out and we really want to know if it is an help to you.

So the first thing is you'll see that on top, the first set of pages, is what we call the measure worksheet, all right? And if you scroll down, what we do is just provide a little brief information so you know what measure we're talking about.

And then as you scroll down, you'll see we've provided sections around -- you can stop right there -- around the different criteria and what staff has done is done some basic review to -- as guidance for your review. We don't tell you how to evaluate the measure, but we point and help you identify the information, we help you remember what the criteria are, we've provided internal links to the document because some of these are rather lengthy where you can find the specific information you will need.

And so we're hoping to see that this is helpful in your thinking and applying the algorithm and then we pose specific questions to you that we really want your thoughts as you're evaluating it against the criteria and these are the kind of comments we would really like to see back in your preliminary reviews, have you discuss in your work group meetings and then ultimately as part of the discussion.

And so similarly, we go through the criteria. The next section is around gap. The next section is around priority and there's one for testing. Now, (Vie), go ahead and scroll back up to evidence. We don't -- you know, it just goes on in a very similar vein.

If you notice -- hold right there for a sec. If you notice, one of the things we're -- we've left blank is a couple of lines for other inputs that are going to happen during the course of the evaluation.

We have posted these measures for comment prior to your evaluation as a result of feedback we've gotten from stakeholders saying they really would like to say something to you before you start discussing and evaluating the measure.

We also have available the opportunity through our Quality Positioning System, QPS, where our measures are available to the public, an opportunity for people to share with us their experiences using the measure.

So if we have any information from any of these resources, we're going to share it with you and put it in this table. And so that's why we call it a worksheet. We're going to build it. When we ask for your preliminary evaluations prior to the work group calls, we'll compile them and put them in here.

So what we're trying to do is bring all the information into one place so that you're not shuffling a lot of documents. And so that's the goal of the worksheet, which is put on top of what we call the measure information.

So (Vie), can you go back up to the top and click on the measure information form so we can go further into the document? You'll see up at the top there's an external link that'll take us into the doc -- you may have to -- OK. There it is.

Now, it looks very similar to what we just were looking at, but indeed, this is a section called the Measure Information Form. This form is created from the information submitted by the developer in response to the questions we ask.

And so everything that's in blue are -- is information provided by the developer. And if -- you'll see that they respond to the different questions. So as you scroll down, you will have a lot of detail and so the basic information is at the head of all of them.

But then you'll see as we move down, there's more information about gap and they provide data. So you'll see that this is the information that we want you to use. We do not expect you to do any independent research, any independent anything else.

So that's going to be the information here on priority and on opportunity for improvement. OK. (Vie), could you scroll back up to the very beginning of that section on evidence? SharePoint, you're kind of slow.

Because what we've done is evidence is a little harder to fit into these boxes. Stop right there. And so what we've done is ask them to provide the evidence in an attachment, which is part of this compiled document.

So you'll see evidence submission form. Can you hit that link, (Vie)? Nope. Down here is a link. Lowest box. Nope, to your right. Thank you. Right there. Nope, the other one. The other one. Thank you. Thank you.

So that is -- the attachment is attached, but as I said, these are kind of lengthy documents, and so we've put a lot of these internal links in there to help you navigate through them. So here's the evidence submission form and it asks the questions that will help lead you through the evidence criteria.

And in the -- at the beginning of this attachment, there are instructions for the developers. So this is what we expect them to do. And then there's a summary of the criteria as a reminder for you and an aid for you.

And then as you go through, you will see what the questions are and what the developers have responded. One of the reasons we're using attachments is because we were finding that the data system we were using to generate the rest of it just didn't allow graphs, tables or other diagrams that are particularly useful in conveying information.

And so we don't -- so we've given them more flexibility with these attachments. And so (Vie), if you'll go ahead and go back to the worksheet at the front, you'll see that those links will help you navigate. The links on the worksheet will take you to the evidence attachment. It will take you to the testing attachment.

So anything that's a document like this, we've compiled together so it's all in one place so you're not shuffling documents; however, many of the measures are also submitted with spreadsheets, spreadsheets of code, spreadsheets of algorithms.

There may be the information for e-measures. And so those will be in the document set on SharePoint on additional information. And we will try and point that out to you in our staff review so that you don't overlook it and you know that it's there as something you should take a look at.

So we've tried to organize the information for your review in a logical fashion, if you will, and again, we're trying this out with several different committees and we would really value your feedback in terms of how helpful it is and particularly how we can make it better, if it is helpful, how can we improve it.

And so that's our measure information form and worksheet. As we are finishing up our reviews and creating these worksheets, we will be posting them on your committee website. Right now, you can take a look at 521. The entire document set is up there so you can see what it looks like.

The rest of the measures will be going up over the next week or so. And so at this point, any particular questions from anybody? Really, the important thing is to know that these things exist and to really go explore and take a look at them yourself.

(Judd Hollander): This is (Judd Hollander). I have a question more about process than the evaluating of each measure.

(Reba): OK. Sure.

(Judd Hollander): And on the work group calls that I see on the list, I'm assuming that we're going to be divided into specific work groups? And I was just hoping...

(Reba): Yes.

(Judd Hollander): ... that you could explain that process unless I missed it somewhere along the line.

(Reba): Sure. We have gone into a lot of detail (inaudible).

(Judd Hollander): And then are we going to be on every one of those calls or...

(Reba): No. What we're going to do -- again, we're trying to divide the workload. There are, at this point, 16 measures. So we're going to divide you into groups. And the folks on the work group will be really responsible for the in-depth review of the measures for their work group.

And we used to just ask for preliminary reviews, but we've had the steering committee members ask to be able to meet and talk with each other as the work group prior to the in-person meeting. So that's what we've set up for you to be able to do.

So we would want you to meet and start talking about the measures. The measure developers are on the line so they can answer questions, make clarifications, you know? If this is a -- this will be a time if you have questions about the criteria, you're not sure how it applies or not, you can talk about it.

So it's a -- it's a chance to do a first run-through, raise the issues, but no, you're -- you are welcome to attend all four calls, but we really would only expect you to attend the one call that you're assigned to.

(Judd Hollander): OK. Thank you.

(Reba): Sure enough. OK. I'm going to let (Inaudible) tell you what our next steps are.

Female: OK. Thank you, (Reba). So based on what (Reba) has just presented, we are having two calls for questioning and answering. So if you have any questions as it relates to the measure evaluation -- and again, we stress that you go into SharePoint and familiarize yourself with the option, as well as, go into measure 0521 just to kind of see how it's set up and if you have any questions for that.

Also, we will be doing a preliminary evaluation survey and that'll be based on your work groups and as (Vie) pointed out, that tab is on your left-hand side. As more information is made available, you will be able to go into that and make your selection.

It will be available by the 10th of February. Additionally, we do know that you need to be here in person for the in-person call -- meetings in April. So you will be contacted by our Meetings Department for your travel logistics and any information as it pertains to that.

Lastly, we will be breaking you guys up into work group calls as (Reba) mentioned, and we will post that assignment on SharePoint so you can have an idea of the measures that we ask you to evaluate.

And as mentioned, our in-person is April 21st and 22nd. And again, just our contact information, again, if you have any questions about anything within our process, our policies, our procedures, any technical assistance you need in the measure evaluation and the worksheets associated with that, please contact us.

These are our email addresses. You can always send us an email or reach us via phone. But also, we try to place all of the reference materials for this project on SharePoint. So your best bet is to first go into that site and if, in fact, you do not see the information that you're looking for, we always encourage to reach out to any of me or my colleagues.

And with that being said, are there any questions?

Mary George: This is Mary George and I have one...

(Reba): Hi.

(Ellen): (Inaudible). I have on my schedule, and this may be from an earlier email, that there was a conference call on February 3rd and February 12th.

Female: I'm not sure why and we can definitely talk more about that offline. I'll definitely get in touch with, (Ellen). I apologize for the inconvenience, but we do not have any calls scheduled for that time. But I will definitely follow-up with you offline.

(Ellen): OK. Fine.

Mary George: This is Mary George and I had one question, (Reba). I think you can answer this as a follow-up to Dr. (Ting's) question is NQF still allowing measures to be considered for a retired or reserved status?

(Reba): Yes, we still have the reserve status and that's a bit of a nuance in measures that are sort of topped out, if you will, where most typically they've often very quickly found themselves with very high levels of performance and not much opportunity for improvement.

If you feel the measure is still very, very good, but just topped out, that can be placed in reserve status. So that is still an option. For new measures, that wouldn't make sense.

Mary George: Right. Thank you.

Male: I just wanted to confirm what you just said about the February 3rd and February 12th. Those -- there's nothing scheduled for those dates; is that correct? Because I had something on my calendar as well.

Female: OK. So we've actually identified what it is. You were selected as part of our cost and resource use technical panel, so you were invited to those individual calls which were on February 3rd and February 12th.

Lindsey Tighe: Yes. And just to be clear, that's only a small subset of the entire standing committee as the majority of you will not be on the call on the 3rd and 12th. Only those who are participating on the cost and resource use expert panel.

(Mark Valentine): Hi. This is (Mark Valentine). If there is a conflict like out-of-state travel and things that on -- I'm personally going to be unavailable for the February 12th call, which I'm scheduled to be on that call, how do we handle issues like that?

Female: We'll definitely reach out to those individuals who are part of the February 3rd and 12th. That as she mentioned is part of the cost and resource use project, but I will definitely touch basis with the 5 individuals who are affected by those calls.

(Mark Valentine): OK. Thank you.

Female: No problem.

Male: And on a similar schedule note, do you know what the schedule is for the April 21 and 22 meeting?

Lindsey Tighe: Hi. This is Lindsey. We did realize after the meeting was scheduled that it does fall the day after Easter Sunday, and so we're discussing internally perhaps starting the meeting at noon that day so that folks can travel the Monday morning rather than traveling on Easter Sunday.

We'll send more information when it's available though.

Male: OK. Thank you.

Female: Are there any other questions?

(Henry Ting): Yes. This is (Henry Ting) again. I'm sorry if I'm dominating with some of my questions, but I'm just curious as to whether -- when there is insufficient evidence of feasibility and usability, does NQF differentiate measures that are better suited or intended for quality improvement and discovery versus measures that should -- could be used for accountability and containment?

(Reba): Certainly. At this point in time, we really are focusing in on the measures that are used for accountability. There's always have been and continues to be

discussion around whether we need to have different classes of measures as such that, you know, designate some only for the quality improvement uses.

At this point, we do not. So you really do need to think in terms of them being appropriate for accountability purposes.

(Henry Ting): Thank you.

(Reba): Sure.

Female: Are there any other questions? OK. We have 15 minutes to spare. We will end the call. Again, if you do have any questions as it relates to anything within the cardiovascular project, please be sure to reach out to myself or any of my colleagues and, again, we look forward to talking with you and working with you on this project. Thank you so much.

Male: Thank you.

Male: Thank you.

Male: Thank you.

END