NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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Operator: Welcome to the conference. Please note, today's calls is being recorded. Please stand by.

Reva Winkler: Hi everyone, this is Reva Winkler, at NQF along with Lindsey Tighe and Vy Luong. Thank you all for joining us on this fourth workgroup call for the cardiovascular standing community. Today, we're going to discuss four measures. Thank you to all the workgroup members for doing your preliminary reviews in submitting your comments. We're putting those comments into the worksheet for your measures on SharePoint. Vy, have you updated those?

Vy Luong: Yes, I did.

Reva Winkler: OK. So if you look at them now, I think you should be able to find the comments submitted by your colleagues. So I just wanted to check and see if we have who from our workgroup. I know I heard from Ted Gibbons, Tom James, Jason Spangler, Mark Valentine, do we have any in the other workgroup members on?

Christine Stearns: Hi there, it's Christine Stearns.

Reva Winkler: Great. Hi Christine, how are you?

Christine Stearns: Well, thank you.

Reva Winkler: Great. Good to hear from you. Is Joel Marrs on yet?

Joel Marrs: Yes, this is Joel Marrs.

Reva Winkler: Great, Joel, thanks so much for joining us. And Mladen Vidovich?

Mladen Vidovich: Yes, speaking.

Reva Winkler: Wonderful. So we have everybody. That's great. So we'll go ahead and get started.

Just, we do have four measures and we have two hours, so that gives us a little bit less than 30 minutes a measure to discuss, so we do want to be sure we have time to talk about all four measures and give everybody an opportunity to raise any of their issues. We do want to focus in on areas that you all feel were, have, might be some questions, concern, perhaps controversy, for things that everyone seem to agree on, perhaps we don't need to spend as much time agreeing. And so with that, let's go ahead and get started.

The first measure is 2458 Heart Failure Left Ventricular Function Testing. The primary discussant is Ted Gibbons. And Ted, if you could just describe the measure and then proceed on to your thoughts about the evidence for this measure?

Ted Gibbons: Sure. So this measure is submitted.

Reva Winkler: Whoa.

Ted Gibbons: I'm getting some background, some feedback.

So this measure is submitted as a process measure by CMS via the quality insights of Pennsylvania group. And it's a measure that is meant to measure, to report LV function measured at least once within the 12-month reporting period from the date of service, ordering a heart failure hospitalization. And in contrast to two of the other measures about heart function or (LV) function reporting, this is based on a reporting body being the practice group or clinician rather than in the hospital.

So this is a measure which is to me, a little bit difficult to understand in some ways, primarily because there are two other measures that document this and I think that spirit of the measure is to be able to capture such individuals where LV function has not yet been documented or it has been a planned documentation at the patient's time of discharge for acute heart failure and hospitalization.

So, I'll get to what I think are controversial issues as we go along but I think going through our checklist of evidence to support the measure focus, it certainly is a class 1 recommendations in measure, left ventricular systolic function in congestive heart failure. I don't think there's any separate evidence to support reporting it by clinician versus hospital, although it would be a reasonable thing to focus on potential performance gap in that regard.

Moving on to the performance gap, the developers action report, two years of registry data, you know, I would be interested to know where this registry resides and perhaps they can tell us but this registry data were from 2011-2012 and were actually from a fairly small number of patients, 41 practices in 2011, comprising by my importing the data into a spreadsheet for only 877 patients. But they recorded a performance gap at that time in the 25th percentile of the registry of 13.8 percent and above 21 percent in the 10th percentile.

But in the follow up practices, not all of them being the same practices, there are only 13 as opposed to 41 practices comprising only 287 patients. The performance gaps, the gap at the 25th percentile had fallen from 14 percent to zero and from 20 percent to 10 percent and the 10th percentile. So given the difference in a relatively small number of patients, the performance gap seems to be fairly small, but it may be different in a larger data set. So it would be interesting to know where that registry comes from and why the had such a small number of patients included.

Reva Winkler: Great. Do we have anybody from the measure developer on the line who could respond to those questions?

They're all …

Ted Gibbons: That would – yes. That would be quality insights, I think who were the developers who were contracted by CMS.

Miriam Cannon: Yes. Hi this is Miriam Cannon from Quality Insights. Gary Rezek, are you on regarding the testing data, our statistician?

Gary Rezek: Yes, I can – one thing I can address is the performance gap, different comments on that given that this is, you know, a low numbers of providers who are reporting this NQF registry that I would have to take to make any sort of generalizations about the you know, performance rates for this measure in general. I mean, for those who are reporting, (obviously) in the 2012, they're reporting very high performance rates. We don't, you know, we can't say if that's the, you know, how that relates to the performance rate of all of the providers if they were reporting.

Ted Gibbons: All right. And so this was a voluntary reporting?

Gary Rezek: Yes.

Ted Gibbons: OK. And where, what kind of registry is it? Is it a national registry or a regional registry?

Gary Rezek: I can't respond to that. These are the data that were supplied to us by CMS as far as I know, there's all of the reporting that – registry reporting for this measure that was done in those two years.

Ted Gibbons: OK. And is this a PQRS registry or is it another one?

Gary Rezek: It is a PQRS measure.

Ted Gibbons: It's PQRS measure? OK. Now, within the measure data, it also has the implication that one would expect to be able to define disparities in LV function measurement based on ethnicity or socioeconomic class. But is that type of data available on the registry?

Gary Rezek: No, it's not.

Ted Gibbons: No. So that was a wish list. It wasn't something that would expect to do reporting. Is that correct?

Gary Rezek: Yes. Ideally, you know, we will have, you know, patient level data with demographics. We simply didn't have that data available to us (inaudible).

Ted Gibbons: OK. All right. So I guess one of the things about the performance gap that I still wonder about is that when one looks at the other heart failure measures of 0079 and 0135 which are outpatient reporting and hospital measures – whether the performance gap that would be narrowed by this particular new measure, whether you can estimate what the impact would be over and above those other two measures.

Miriam Cannon: Hi, this is Miriam Cannon. I don't believe we can estimate that at this time.

Ted Gibbons: OK.

Miriam Cannon: There's a little data that we have.

Ted Gibbons: All right. So just getting back to this period of the measure itself, what was the overwriting intent of developing this measure separate from the other two then?

Miriam Cannon: The overall intent is to provide a way for eligible providers to report this measure on an outpatient basis. You know, whether the …

Ted Gibbons: Would this be a pay for performance type of thing or is it a …

Miriam Cannon: Yes. It could be a linked to a pay performance. Yes.

Ted Gibbons: OK. All right. So this is just to augment the documentation of clinical care in the outpatient setting?

Miriam Cannon: That's correct.

Ted Gibbons: OK. All right. Anything else, Reva, from there (inaudible) move on?

Reva Winkler: No. And just the one thing I wanted to clarify is if this measure is for patient that captures – patients who have been hospitalized – who are hospitalized with the principle diagnosis of heart failure. So even if it's an outpatient measure you're still limiting it to patients who don't – have been hospitalized within the past year?

Miriam Cannon: That's correct. So the denominator would be those that were hospitalized in the past year.

Reva Winkler: So it's not all patients of heart failure?

Miriam Cannon: That's correct.

Reva Winkler: Anything from any other workgroup members on the …

Jason Spangler: Wait. Wait.

Reva Winkler: … absence or a gap?

Jason Spangler: I'm sorry. Can you clarify what was just said? I think I misunderstood. So it is patients who are hospitalized with the principal diagnosis of heart failure, right?

Ted Gibbons: Yes.

Miriam Cannon: Who were hospitalized in the previous …

Ted Gibbons: Within the last 12 months.

Miriam Cannon: Yes.

Jason Spangler: Right. OK. OK.

Miriam Gibbons: To identify those that need LV testing.

Jason Spangler: So Reva, this is Jason. My concern about this measure around the evidence is that, you know, it is – as (Pam) said, you know, class one recommendation for – but my understanding is that the diagnosis. And event the guidelines talked about – it is, you know, LVF – it's the single most important diagnostic test in

the management of all patients. And my question is do we have evidence – and maybe I'm not aware of this and I didn't see in the evidence that measuring left ventricular function – systolic function actually improves outcomes related to patient with CHF.

So the measure itself, obviously, you know, most of the time that these patients have already been diagnosed with CHF. There already on treatment, you know, they're already on some sort of treatment. Usually the treatment is tailored – to my understanding – usually based on symptoms and functional activity or functional ability not necessarily just by measuring LVF. So I'm wondering, is there actual evidence that actual measuring LVF on a, you know, a basis like this actually improves health outcomes in these patients?

Miriam Cannon: Not directly. I can research that but the measuring of LV function in a hospital is important as part of the treatment plan for a patient.

Jason Spangler: Right.

Miriam Cannon: So it's a combination factors.

Jason Spangler: Right.

Miriam Cannon: And a hospitalization for heart failure would signify a deterioration in their heart failure status. So that it'll be function then would be able to direct management and outcomes but it is not directly attributed to that one thing of combination of factors.

Jason Spangler: Right. And so, it's a combination of several things that are done. And then – so it's more along (inline) with your logic algorithm.

Miriam Cannon: Yes.

Jason Spangler: OK.

(Crosstalk)

Ted Gibbons: But it's not a composite measure.

(Julie Anne Lapina): This is (Julie Anne Lapina). If can interject here. I am heart failure transplant cardiologist and you're correct. The actual measurement doesn't change outcome. So nobody's shown that. But what the actual measurement would do and it's obviously a two-step process is up – sort of show the clinician the way to treat that patient and what not to give them.

So because there's such a difference in high EF heart failure and low EF heart failure as far as therapy, I'd sort of the road of map to the right therapy and the road of away from that therapy.

Jason Spangler: Go it. Got it.

(Julie Anne Lapina): Pardon me for butting in.

Jason Spangler: No, no. I am appreciative that you did that because – so that's my – yes – so it's – there's no direct evidence but there's more of evidence of, you know, which pathway do you go when it comes to these patients. Now, my question related to that is the time period. Is that something, you know, as a heart, you know, as a congestive heart failure – a heart failure expert – that is there evidence around time periods of measuring left ventricular function, post hospitalization?

Is there any evidence about – is 12 months a good period? Is it better do it, you know, more frequently? Is there any – I'm not aware of any. So you probably know better than I do.

Miriam Cannon: Yes. I'm not aware of any either. We generally say that's once the patient has been optimized with good doses particularly of beta blockers for minimum of three months, you may come to a decision point as to whether to put an ICD in or not. And at that point, you may want to remeasure. So don't routinely remeasure at any time period unless the patient's clinical presentation is changing.

Jason Spangler: Got it. Thank you.

Mladen Vidovich: I have one question this is Mladen Vidovich. This measure specifically says measurement within 12 months. Is it possible that some provider might then

ignore changes is in clinical status and not remeasure EF if they feel comfortable that it had been done in 12 months as recorded? That is one of my concerns about this measure because clinical situations may change.

Miriam Cannon: I guess that's high experience. I believe it's the 12 months would be – again, those that are hospitalized so that would signify the change in status. They could do a repeat if they were hospitalized the second time but the measure requires one (only) testing?

(Crosstalk)

Mladen Vidovich: That's one thing I was confused about as well. It is the clock start when the patient is hospitalized or is it retrospective and prospective six months before and after for instance? Is it – the clock started at time zero with the hospitalization.

Miriam Cannon: The clock is – its in annual measures so, it's from January to December. So if they're hospitalized any time that measurement year, they will be required to have LV function test during that measurement year. So it could, you know, it would be – those are hospitalized that would be the, you know, that would put them in the denominator. And then, you would look for LV function testing any time during also the same reporting year.

Mladen Vidovich: Right. But I think that goes to the point of about optimal measurement that if someone hospitalized in January and doesn't have a LV function measurement till June, that's of optimal care.

Miriam Cannon: Yes, however the measure does allow that.

Mladen Vidovich: Yes. Right that's one. Well. I think we're jumping towards specifications so …

Miriam Cannon: OK.

Reva Winkler: Although I think if – unless there are any other comments on the first criteria, we might as well move to specifications.

Mladen Vidovich: Sure.

Thomas James: This is Tom James. I just to make one other comment right along that line. I'm speaking as a general internist. This line – this particular measure as a process measure is somewhat analogous the one in COPD requiring spirometry. So it's not that it's in isolation but its part of disease specific process measures.

Reva Winkler: All right.

Thomas James: OK.

Reva Winkler: Ted, why don't you go ahead and talk about specifications and then reliability validity testing.

Ted Gibbons: OK. That's sounds good. And I know we're – we have a timeline. So I'll just – I wrote quite more – a bit more than I need to say because we've talked about some of the specifications. But since the measure developers are there, I am grateful for their comments on this.

The specifications – what to be reported – what LV functions to be reported but they actually mentioned specifically the components of left ventricular ejection fraction measurements including stroke volume and diastolic volume which is obviously how you calculate the ejection fraction that is not clear that they want all of those three reported. I assumed they do not. Is that correct?

Miriam Cannon: That's correct.

Ted Gibbons: OK. And then, they go on with the – a discussion of the fact that the gold standard for measurement is echocardiography and mentioned things including doctor and disease (inaudible) heart disease structural manifestations of left ventricular remodeling which I think is more of the discussion rather than trying to make distinction between heart failure with preserve ejection fraction and reduce ejection fraction.

So all that you are asking to report is the ejection fraction, correct?

Miriam Cannon: Well, the LV function testing.

Ted Gibbons: Right. Yes. But what you mean by LV function is left ventricular ejection fraction. Because there are many other ways of measuring LV function.

Miriam Cannon: Yes. That's correct.

Ted Gibbons: That's correct. OK. So one of the – is I think we all ready talk about the delay in perhaps, diagnosis if someone hospitalized in January and doesn't get an echo till June. But I think it would be interesting to know why that gap is allowed within this measure. And it just seems to be contrary to the in-hospital measure by the ejection fraction for acute heart failure.

Miriam Cannon: OK.

Ted Gibbons: So for instance, if one …

Miriam Cannon: No, I know what you think – did you – what – looking for a response there? I know if it's contrary but, you know, it's – the difference is when it can be reported. Yes.

Ted Gibbons: Correct. So if this is a voluntary registry, I could conceive of a measure where you would require that there are be reporting by a clinician or practice the ejection fraction were measured within a month after discharge or something like that. Was that ever considered or was just measured – just a quality measure that's more broad?

Miriam Cannon: It's meant as a quality measure but it's more broad. Yes.

Ted Gibbons: OK. OK. Anything else about specifications, Mladen? OK. Then, reliability testing. Based on the reliability testing in the measure, the reported reliability from 2011 to 1012 was reported 0.49 and increased into 0.69 based on about 1,100 patients.

And I would think that the reliability improved in the second year primarily because performance increased 100 percent in most of the patients. So I don't know that that really tell us that reliability has been proven but it is encouraging that the reporting clinicians did better. Was there any other evaluation of reliability, Mladen?

Mladen Vidovich: No, that's – there wasn't and I agree with your information of that completely. It is difficult to say with firm reliability given that we only had performance data on relatively small number of cases.

Ted Gibbons: OK. Thank you. Validity testing was primarily face validity based on what's (supported) as stakeholder input expert panel discussion and public comment. I would say that the validity of the measure really has intrinsic value and face validity based on the fact that I think everyone has agreed that it's important to the clinician make clinical judgments based on the knowledge of ejection fraction. But I think there it only face validity on that basis. Threats to validity. Can you – can the measure developer say why that you're excluding clinical trials – patients in clinical trials?

Miriam Cannon: Actually, I don't I don't have any answer to that. I don't know if, Gary, you do? I don't have a reason in particular.

Gary Rezek: No.

Miriam Cannon: No.

Ted Gibbons: I don't think it makes a huge difference in the reported data sets. The exclusions we're less than 5 percent to the each of the group. So – but it still would make it a question that I have, but it's I don't think it threatens the overall validity of the measure.

Feasibility. In terms of feasibility, I think in a voluntary self-reported clinical data set that it is visible to generate this. I think it maybe confusing for clinicians who are familiar with the other two measures to wonder whether the satisfaction of this measure requires a remeasurement of left ventricular function but I think that could be aviated by making the measure description in the reporting registry a little bit more obvious.

The other thing is it is a burdensome description. I think it's probably is not. Most practices I would think have electronic medical record access where they can find the data fairly easily. It's also true that those practices are being brought up and subsumed by hospital group. So I think the unified electronic medical record will make that fairly easy to do, to use.

In terms of usability of use, it's – is I think usable. I still wonder if the competing measures are satisfy the same requirement. And I'm not sure that based on the data showing the registry improvement actually justifies having a separate measure but I'd be interested in other comments from the other committee members.

Gary Rezek: Yes. I would agree that I don't think there would be much benefit from a separate measure that that is my feeling and then I think that just documenting that there wasn't EF assessment within last 12 months. May not – may on occasion be deleterious to patient care because you can just check off the boxes. Yes, we did it. But in clinical circumstances may change and that may impact patient care. That they be might feel.

Ted Gibbons: And I agree with that. I think that this maybe stronger as a composite measure where there's an action plan based on the process measuring LV function then do you document on the same setting that the patient is on appropriate therapy whether it be beta blockers, ace inhibitors, spironolactone, and so forth.

Reva Winkler: OK. All right. Any other thoughts from any other workgroup members or on this measure or perhaps you might be ready to go on the another measure?

OK. Why don't we go on to the next measure then? This is measure 0521 Heart Failure Symptoms Assessed and Addressed. This is a measure for home health agencies and this measure is based on data from a standardized data collection instrument called OASIS. We've provided the link to OASIS tool if you're interested in looking at the specific details. And I know the developer is on the line.

So Mark Valentine, I think you're the primary discussant for this one. If you could describe the measure and talk about your thoughts on the evidence and gaps? Mark, are you there?

(Arthur): Hi, this is (Arthur) and (Deb). Would you like to take this on?

(Deborah Gibb): Well, I think Mark Valentine was going to speak, right?

Reva Winkler: Yes. I was going to say any of the workgroup members. If Mark had to step away, Christine, you're second on this one.

Christine Stearns: OK. Hold on. Pulling up my notes. OK.

So this measure is the Heart Failure Symptoms Assessed and Addressed. This is the process member – sorry –process measure with some moderate evidence that is something heart failure patients for symptoms during homecare visits would result in better care and less need for urgent care.

Do we want to – any questions or you want to move on to the on the evidence to support the measure?

Reva Winkler: All right. Your thoughts on – yes, move on to the evidence. Correct. OK.

Christine Stearns: OK. Hold on. Let me just flip over to my – OK. So there was a moderate amount of evidence to support this. I'm sorry I thought I had my notes printed but I do not. The developer had used this as the guidelines on the Heart Failure Society of America to – let's see – so the present measure – the assessments for …

Female: Hi, Christine. The workgroup comments are up on the webinar if you want to take a look at it.

Christine Stearns: I'm sorry. Thank you.

Female: Sure.

Christine Stearns: Yes. I know. I can't see that and I forgot my glasses today. So …

Reva Winkler: Any of the other members to the workgroup want to weigh in on the evidence for this measure?

(Deborah Gibb): This is (Deborah Gibb) from MAP Associates. Would it be helpful for me to give a brief intro to the measure and then you guys could recall maybe your discussion?

Reva Winkler: Sure, (Deborah), why don't you go ahead.

(Deborah Gibb): OK. So this is the Heart Failure Symptoms Address has been an NQF endorsed measure that's been reported on home health compare since 2011 and as currently specified, the measure assesses whether the clinician addresses the patient symptoms if they have symptoms of heart failure. And we're proposing revising the message measures so that it is – that they address any symptoms that are there whether or not the patients is having symptoms.

So any patient that has heart failure. And the measure will also apply to short-term and long-term episodes. In the past, the measure has only applied to the shorter term episodes of home health care. And we did some analysis that indicated that that long-term exclusion was not necessary. It was not creating burden to include both short and long-term. And that the – it didn't distort the measure and increased the denominator when we included both long and short-term. So that's a brief introduction to the measure.

Female: Right. Well, thank you for that.

Reva Winkler: Does anyone have any thoughts around the evidence for this measure? Does it meet the criteria?

Jason Spangler: So this is Jason. I thought there was low evidence here. It didn't seem like a QQC was provided and the three guideline recommendations that they cite as evidence were only moderate in strength. So according to the algorithm, to me I think that pointed to low evidence.

Reva Winkler: Right.

Jason Spangler: If I was reading that correctly that algorithm.

Reva Winkler: Yes. All right. (Inaudible) anyone else? Ted, I'm going to put you on the spot.

Ted Gibbons: OK.

Reva Winkler: Did you have a chance to look at this measure?

Ted Gibbons: Yes. I did. I had a couple of questions about just the logistics of how it's reported. Is this – is the data from this entered by anyone with the clinical contact with the patient who was home bound with the history of heart failure or is it have to be an MD or a nurse practitioner or how was the assessment done? Is it done with the checklist in a scripted dialog about assessment of symptoms?

Miriam Cannon: The measure is recorded during – at the discharge of the patient when the nurse who was been caring for that patient fills out the OASIS data set and determines whether or not during that episode of care the patient had symptoms, and you know, documents whether or not there were specific responses and which responses were which actually for taken in response to the heart failure for symptoms.

Ted Gibbons: So this is a single entry of data based on the discharge from home health?

Miriam Cannon: Yes.

Ted Gibbons: OK. So if the patient has symptoms during the assessment of the serial assessment, is that a separate reporting mechanism?

Miriam Cannon: I'm not sure what you mean by this serial assessment.

Ted Gibbons: Well, I guess question is, is this – if someone has a home health visits for six weeks, is this done at the end of six weeks or is it done at the end of the visit?

Miriam Cannon: Yes. No, it's done at the end of six weeks and it's a review of all the care that the patient had during that episode.

Ted Gibbons: OK. But if the patient has symptoms three weeks into the six weeks, does the reporting happen then and then the intervention made?

Miriam Cannon: The reporting would at that time be done in the medical record, not a medical record is part of the resource that used for the person who's completing it. The site I'm in the OASIS.

Ted Gibbons: OK but in general, the reporting is not at the end of the said care.

Miriam Cannon: Yes.

Ted Gibbons: OK.

(David Hiddle): And this is (David) – this is (David Hiddle) just to clarify, it's done retrospectively for across the entire episode of care. So they would look back through the notes for the entire episode of care. You see if at anytime they had symptoms that and whether they were addressed appropriately.

Male: And within by address, you mean that they were – that they have been documented or that there was communication with their clinician?

Miriam Cannon: Well there are several appropriate responses to the heart failure symptoms and that includes communicating with the physician or implementing if there were – if the physician had already ordered the specific actions to be taken based on parameters or education or other clinical interventions, those are the kinds of things that are documented.

(David Hiddle): But primarily this would be documenting stability or lack of stability at the end of episode of care, is that correct?

Miriam Cannon: It's indicating what actions that were taken in response to instability.

(David Hiddle): I see. OK.

Male: Do we have evidence that those interventions have improved outcomes?

Female: Or sir, is there any – did we – did Acumen do any analysis on change in heart failure rate, symptom, rate over the – I know we've done some of these four measures that have been reported for multiple years. We've done some analysis about how rates changed and I don't know whether we did that for this measure.

(Alex): Hi, Ted. This is (Alex) from Acumen. I'm looking at specifically at the change of heart failure rates, we haven't looked at this specifically. One area we have looked at to see if there's improved outcomes, just jumping at the validity, we might – we looked at how this measure would correlate with improvement across some other health hold out outcomes.

So it's not exactly related to heart failure but this is – I think this is something we could investigate further. I think they'll be useful for the committee.

Reva Winkler: Any other stuff of evidence and if not how about the gap or the opportunity for improvement?

Christine Stearns: This is Christine. The measure developer said submitted 92.2 percent results would seem to be fairly consistent and if there are no sort of gaps along gender rates which I guess call the question of their continued need.

(Deborah Gibb): When I was looking – this is (Deborah) again. I know that we showed a performance gap from the 90th to the 10th percentile of 16.7 percent using the new specifications and 9.5 percent gap between the 25th and 75th percent.

Christine Stearns: OK. Thank you.

Jason Spangler: This is Jason. Do – it didn't seem like there are any differences around possible disparities or those who were minimal as well. Is that correct?

Female: That is correct and that is one thing that we didn't notice that you have retooled this measure a little bit, to be more expensive that there were of what you're proposing today from – to include more patients who would previously not have been included in the measure.

Female: You know, previously included just patients who were exhibiting heart failure symptoms now it's anybody with heart failure.

Female: Right.

Female: A diagnosis of heart failure.

Female: And one question that I had you indicate that there are 8,000 home health agencies, 8,822 using this – that you looked up for this reason the specification. Is that who's using it actively now?

Female: I'm going to defer to Acumen.

Male: Sure, so that's a number of agent home health agencies that with – that we're reporting in our kind of a time frame which is June of 2012 to July of 2013.

Female: And do you know what percentage of overall home health care agencies that number represents?

Male: I imagine that should be pretty close to 100 percent of home health agencies.

Female: OK.

Reva Winkler: Any other discussion on opportunity for improvement of disparities? Somebody want any comments on priority?

Male: I wanted to clarify on the number of home health agencies, that's just a number of agencies with 20 cases, is that correct?

Male: Right, that's correct, I just know that that's from my end as well. So I think all home health agencies represent I think somewhere around 11,000 and that 8,822 is all agencies without at least 20 valid home health episodes for this particular measure.

Male: So it just effectively excludes really small agencies but.

Male: Right.

Male: They don't have enough data.

Male: One of the hidden disparities that can't be reported is the fact that home health is not supplied to some individuals that don't have adequate coverage.

Female: This measure only reports on patients who have Medicare and Medicaid.

Male: Right and in some regions, Medicaid does not cover home health either. So there's a hidden disparity there.

Reva Winkler: Do we want to move on to scientific acceptability, any comments from the workgroup on the specifications? I think that the data elements are those

defined from the OASIS tool. We gave you the link to the actual tool if you wanted to look at it directly as well as what's in the submission.

Christine, what are your thoughts on the reliability testing?

Christine Stearns: That – It looked like it had done well with the reliability, we had a couple of tests of the date sighted. We have 78 percent would seem like it would pass the sort of minimum requirements which are 0.75 percent for reliability and for validity although it reached the basic requirements has being sort of a valid measure.

And so, you know, its goal is took a process measure of whether or not it is achieving their goal. I think that question is whether or not at having an impact which we don't have internship.

Reva Winkler: Thoughts or maybe of the other committee members on the reliability and validity testing?

Jason Spangler: This is Jason. It seems like – sorry I was by the algorithm again, I thought it has moderate reliability, I mean it did use the beta-binomial model can measure signal-to-noise and then it also has the interclass correlation coefficient.

Female: right.

Jason Spangler: But it seems like that if because the number was kind of just above the threshold at that that point into moderate reliability and then, you know, I agree, you know, the face validity was done and there was a majority percentage. My only concern about that is I think it was I'm trying to pull this up here. But wasn't there only like five of the eight people or it seems like the absolute numbers seemed really small with the face validity. Even though the percentage seemed OK.

Female: Are you referring to the …

Male: Yes the number at the top …

Female: Yes it was five to eight, deemed.

Male: Right, right and I know that's the majority but it just seems like because looking at other face validity done with some other measures including measure in this workgroup there're, you know, there're much larger absolute numbers. So that was my only concern about the validity.

(Deborah Gibb): This is (Deborah) I just want to mention that one of the impetus for us revising the measure was partly concerns that were expressed by the technical expert panel. So the changes were in response to have concerns. Well I think that I'm just saying I think the face validity numbers would be higher with this new, with the new specification.

Female: So that the five out eight is for the …

(Deborah Gibb): you know the higher specification and they said …

Female: The previous, not the currently proposed.

(Deborah Gibb): Right. And so this is in response to comments that were made, to include everyone with heart failure and do not exclude the long term.

Male: So then with face was face validity testing done again with the new specification or not?

(Deborah Gibb): We have not, we did not we were not able to reconvene with that after those changes, you know.

Male: OK.

(Deborah Gibb): But as I said they were in response to those changes to their comments.

Reva Winkler: Anything else about reliability or validity testing? Any concerns from anybody on the workgroup on any of the threats to validity particularly around the exclusions? Very straightforward.

Male: Are you trying for the question in general. Sorry, it was just – it seems like risk adjustment is not done for a majority of these measures. Is that – are we

supposed to count that again because I didn't see that anywhere. I mean it's not just something extra.

Female: Is general process measures rarely risk adjusted?

Male: Yes, yes.

Reva Winkler: However in the other workgroup they have outcome measures and risk adjustment is a huge part of it. So it's just kind of a part of the criteria that doesn't really apply to these measures. But does to others.

Male: But, yes, that's what I'm saying but I was just making sure we weren't supposed to if risk adjustment wasn't done in these, we weren't supposed to kind of penalized them so …

Reva Winkler: Not at all. OK. I think we talked a little bit about the current – the performance data, the result of this measure and in terms of (inaudible) for improvement and does the measure provide information that provides meaningful differences to understand the quality of care provided by home health agencies. Any thoughts from the workgroup on that aspect?

Thomas James: Yes this is Tom James and I'm curious is this the measure that's on home healthcare.gov? The one that says how often does the home health team treat heart failure parenthesis, weakening of the heart sick patient symptoms. And if it's not the same measure that Medicare is currently reporting what is the difference between this measure and that measure?

Female: This measure is reported, is it that measure (inaudible)?

Female: Yes that how, that's the consumer friendly wording for it.

Thomas James: That's what …

Female: And so the slight difference they get. So the only difference between what's currently reported on home health compare in this measure is both changes in the specification that we've discussed.

Thomas James: OK so from the consumer point of view it's not likely that they're going to be peaking up much in the way of differences. They would change the way that they perceive one home health agency versus another when they're given the option in the – at the time of discharge to have a particular agency. Is that right or you think that there's going to be significant variation in the reported results for individual agencies?

Male: Well, by changing the specifications, we've increased the amount of variation among providers, there will be a little bit more.

Thomas James: OK.

Female: And there's also going to be more of their work. More agencies that did not have a response for this and could not be rated under the current specifications, we've increased our denominator.

Thomas James: So the AQAs public reporting workgroup and one of the concerns that has been, it that too many measures are ones where there is minimal difference between providers in his case home health agencies and they mean to – the public has no particular opportunity to make an informed decision on one or another when you're going at a couple percentage point differences.

So anything which expands that potential to make it up more understandable is helpful to the consumer.

Female: Thanks, Tom.

Thomas James: OK.

Reva Winkler: And maybe that will also come up as we go down and first we'll talk about feasibility but perhaps your comments will be pertinent for usability as well.

Christine, any up on the feasibility criteria?

Christine Stearns: Well it's currently – this measure is currently in use and it uses standard collection tool, is electronic so it should be relatively easy to collect the data.

Reva Winkler: Thoughts from anybody else? OK. And then I think you were just talking about some things applicable to usability and use that it's currently publicly reported on home health compare and that perhaps the revised specifications will provide a greater variation and a greater range that will make it a little bit more usable for potential consumers.

I think that was Tom James' point, any other thoughts from the workgroup on the usability and use for feasibility criteria.

Ted Gibbons: This is Ted Gibbons, I just want to support the fact that I – I think that it's really a positive sign that other non-hospital, non-traditional clinic settings are focusing on assessment of the patients for heart failure because it's such a huge problem where people fall out of the medical system that anything that we can do to capture instability is going to be a useful thing, I just hope that the measure would in it's brighter form actually has – produces an outcome that is going to be even more positive.

Reva Winkler: So any more thoughts on this measure before we move on to another one? Any more thoughts from the workgroup? OK, well our next measure is a new measure again. 2450, this is heart failure symptom and activity assessment and Joel Marrs, I think you're the primary discussing for this one.

Joel Marrs: Yes. So the specific measures looking at patients who have diagnosis for heart failure that we had an evaluation of the current activity and symptoms documented in the HR essentially, and so just to start off with the evidence to support the measure sighted both ACCF and HA as well as HFSA guidelines in regards to class 1 recommendations for this symptom assessment of heart failure patients.

In regard to level or grading of the evidence, it was level C in the ACCF guidelines but not overly concerning since should be a standard of care practice and chronic assessment and acute assessment of patients. And then the other issues where it was evidence applicable for the process of care being measured and so based on being in the standard of care felt that was appropriate on this realm.

There was some concern because of no QQC provided but felt that the both recommendations having there is a class 1 recommendation in both guidelines felt that it was a moderate to strong support towards evidence.

Reva Winkler: Thoughts from anybody else? Mladen I think you were the second discussant for this one, any thoughts from you?

Mladen Vidovich: For myself, Vidovich? I would agree, I think this – there is – this is a level of C recommendations by the guidelines and evidence is very strong that this is the correct treatment of patients with heart failure and should we continue assessment of the clinical status because heart failure essentially would take care of the symptoms and then outcomes of course but, you know, you want to make the patients feel better and I think that is indisputably true.

There's no good scientific evidence but it's a level of C.

Reva Winkler: All right. Thoughts from any other members of the work – any other members of the workgroup? OK. How about opportunity for improvement?

Mladen Vidovich: So based on the performance gap assessment. They used the PINNACLE registry which was just over 1,200 providers, I think 1250 or so and about a half a million patients included in that analysis showing both in 2011 and 2012 that about a third of patients were showing documentation of this measure in that registry itself and so there wasn't necessarily a huge difference in individual subgroups in that population but overall showed that a kind of a low performance level overall in this registry.

Reva Winkler: Thoughts from any other members of the workgroup?

Mladen Vidovich: Yes. It's really – It's interesting with this measure, it's something that clinicians do daily but it's just not documented, I mean it's very, very poorly documented like a third, only a third documented in this measure.

Reva Winkler: One of the questions I had to clarify is because it's based on the registry, are we measuring documentation in the registry or documentation of say in the patient's record?

Mladen Vidovich: So, the way I understood the registry, I pulled, I pulled the data electronically into the registry and so what happen is they were – of the half the million patients, there was more patients in that but patients who were excluded, data wasn't necessarily pulled in because it was a concern that you would under report the person obtaining this measure or not because it could be an electronic pooling issue or electronic registry issue where the data didn't cross over.

Male: It's uncertain because it's – it's meant to be an electronic medical record, paper medical record, it's probably not consistently documented by some sort of a pull-down menu. I think that's where the – that's such a low, let's say compliance.

Male: What's also – isn't true that there are several instruments that can be used to document exercise capacity and state of well-being? And some of them are more reliable than others and some of them have the report reliability which we'd probably get to in specifications.

So it maybe that the – whatever menu can be chosen doesn't take advantage of what the clinician is used to in terms of documenting, New York Heart Association Class being fairly inconsistent for instance.

Reva Winkler: OK. So anything else on gap, anything on disparities?

Male: There were none. I think it was pretty poorly done across the generally …

Male: Right. There's no main difference.

Male: There's no difference, it was just a script fully done.

Reva Winkler: OK. All righty, anything more can we move on to scientific acceptability? Joel, what do you think of the specifications and the reliability and validity testing?

Joel Marrs: So part of the supplementary documents was on appendix of PINNACLE Registry which basically went through and defined all the criteria hat they pulled in to the registry. And so, looking through those, they look appropriate

but I agree there – within some of those criteria, there's some subjectivity of how patients were assessed potentially from New York Heart Association Classification. But overall it looked appropriate – an appropriate list of specific measures to pull in to the registry and evaluate.

And then, from the calculation that they used, we talk about some other exclusion based on data missing but appropriate calculation in regards to who was be in the measure or not, overall.

Reva Winkler: Thoughts from anybody else?

Male: Yes. It's a very reliable measure, I mean, it's very, you know, that – the signal-to-noise was excellent, right? Validity is the problem, however we will get to that in effect.

Reva Winkler: OK, so you're comfortable with reliability, OK. How about validity?

Joel Marrs: So, basically the registry included about a half million patients. Did have – did show consistent results from 2011 to 2012. And so, potentially applicable to apply to a larger population but not necessarily a large samples size.

Male: See my – yes, my concern was like, you know, if you look at the statistic results for validity testing, it's just like 375, like, you know. And I've – just because – as they mentioned, New York Heart, it might be good at its extremes is one and four, two and three. There's greater concerns that's it's in accurate measure. And there's probably better test that some clinicians maybe using either objectively or incorporating in the clinical decision making process.

So, the question is that is this – should this measure be used for (wider plan) implementation based on this. I have a great concern here that if we say that this should be then measured across the board with not that many people doing it and not being that valid. I do have some concerns, although it does makes sense but it's maybe something very difficult to measure.

Ted Gibbons: Yes. I agree. I think that there's a big difference in a general internal medicine practice versus a heart failure practice where we do a six-minute

walk test and do Minnesota questionnaires, heart failure questionnaires, whereas a general internal medicine office is probably not necessarily equipped unless they have a particular interest to do more specific test. I mean the New York Heart Association Class, you can keep listing class three month after month when you're seeing the patient. But if you do more subtle assessment of how many meds that a patients is actually engaging in on the daily basis, it's a much more reliable measure of change.

Reva Winkler: Difference of the question, Ted. How many non-cardiologist are submitting to this registry?

Ted Gibbons: I can't answer that.

Male: I don't known if any are. Isn't this a specific registry through the American College of Cardiology?

Reva Winkler: Yes. Well, that's what I was wondering …

Male: Yes. I think it only cardiologist.

(Crosstalk)

Robert Bonow: This is Bob Bonow, I'm a cardiologist and one of the developers.

Reva Winkler: Yes, I was wondering if you were there.

Robert Bonow: Ileana and I are both were part of this process, but this is – the PINNACLE registry (close) cardiologist only. So these are cardiology outpatient practices. And so, the point is even in that setting, you're seeing this underreporting going on. So maybe equally better, perhaps, not as good in – an internal medicine practice.

(Crosstalk)

Robert Bonow: We're not recommending that we do six-minute walk test or check the measures of meds. But the point would be that, you know, there maybe qualitative differences from one practitioner to another as to what they (found) a class three patients is. If the same practitioner is following the same the

same patient with time and noticing a deterioration in clinical status, I think that's the important thing. That will trigger interventions that could improve outcome by either moving them now to a more intensive medical therapy adding an aldosterone antagonist considering the patient's (inaudible) cardiac resynchronization therapy. Or referring them – referring them then to a cardiologist or to a (inaudible) heart failure practitioner who might be able to improve status of patient and improve outcome.

Ileana Pina: So, if I can pipe in – this is Ileana Pina. On this committee when we were writing these, we realized and you're right that there are some better tools like some questionnaires that can really hone in on patient function and even have some prognostic capabilities. However, even the average cardiologist does not use those in practice right now. And may not even be familiar with them as we are in heart failure.

However, everyone knows the New York Heart Class and even though it has some imprecision because it is subjective, it pretty much correlates with outcome. And we know that functional limitation correlates with mortality actually, so that there was a strong link. We have the same discussion internally.

Male: So in the reporting, do you have data to suggests when – in the PINNACLE data, if someone reports a patient's move from class two to class three, that there's an intervention or is it, do you have a sense about how often that's reported?

Ileana Pina: I don't …

Robert Bonow: I don't believe we have that at the (site) at now.

Ileana Pina: But it's a great question though to look at.

Robert Bonow: As we were developing our measure set, we actually entertained a measure that perhaps would be one for future consideration about, if there is such documentation of a patient showing worsening clinical status. But then there's a documentation, a record of a proposed treatment strategy to improve the outcome or at least to improve the symptoms status.

So that something that we would to consider developing in the future but, we think this would be the first step of that process.

Male: Well, that seems to be common theme in the process measures where you wanted do a little bit more but you're at least making a stab at documentation at one level. And then, hoping that an intervention will occur based on that documentation.

Male: Yes. I think that implementation of this measure would slowly make a step forward towards quality. And then, I think maybe someway to integrate this in an electronic medical record as a pull down menu would clearly be a very good quality move.

Reva Winkler: This is Reva. Is this – the results of this measure being feedback to the PINNACLE participants at this time?

Robert Bonow: I don't know the answer to the question. I think the – this data will probably get published at some point. And, hopefully that will allow clearer widespread awareness of this, whether it's being feedback to the individual practitioners. I'm not sure how that communication goes.

Jensen Chiu: Actually, Dr. Bonow, can I chime in? This is a staff, Jensen Chiu with American College of Cardiology.

Robert Bonow: Thanks, Jensen. Please do.

Jensen Chiu: OK. I just want to build to Dr. Bonow's and Dr. Pina's comments on that. When this measure set actually was first published, Dr. Bonow is correct. Direct feedback did not occur, but actually we can actually say, all the measures in PINNACLE that have been submitted for the body here are actually being feedback, not just quarterly, but potentially monthly feedback.

So this measure – and actually, to Dr. Bonow's points, he was alluding to heart failure symptom management measure which actually not just looks at assessment. But rather the – rather the patient was actually improving which

is currently internal quality only. Physicians still likely see that data, and that feedback in a continuous basis.

Female: That prompts the question, Jensen. Given the low performance on this measure, how long have you've been feeding it back? And are you seeing any response on the part of the clinician?

Jensen Chiu: No. That a very, very, very question. I think the challenge simply is we're actually finding out and unfortunately this is somewhat anecdotal. But we are finding out that a lot of times just simply not documenting this measure. So, unfortunately – we're not – we didn't submit the symptom management measure. But the symptom management does show the results are gradually improving but the issue is simply is the document – the doctors, honestly, just aren't documenting.

And that's kind of the challenge in – for the outpatient setting in the EHR world, they're having the challenge documenting it but it doesn't necessary mean something has not occurred. Of course, if something is not documented for this assessment measure, we have to assume they – for measurement goes, they're kind of getting dinged if you will. But in a management prospective of things, that measure and it does show grow – growing improvements but still is huge gaps for this one and kind of (correlated) to CD as well.

Female: But nothing that speak to improvement in documentation?

Jensen Chiu: Well, that is correct. You know, the challenge again is we realize that the outcome – rather, the intermediate outcome measure is probably, you know, eventually the measure we want to put forward with this measure, it's kind of like the CD measure where you're actually looking at not just – rather somebody who was assessed – rather, or more importantly, whether symptoms actually managed. But there are some operational challenges that's actually sending that one forward. But that is the goal eventually to actually to have sense and realizing that one's probably more a measure sure that NQF and another constituent really want.

Female: OK.

Male: Is there any consideration of making this part of a composite measure?

Jensen Chiu: Do you mean with – the I'm sorry …

Ileana Pina: If I may, we had talk about that but felt that, as Dr. Bonow said, we wanted people to document functional status of some sort. And this would be the first step. I'm sure that through PINNACLE, we will be publishing what we have found and hopefully the publications will stimulate clinicians to pay attention and to actually document this.

Reva Winkler: All right. So we've talked – anymore discussion of reliability and validity of the measure. OK, we go down to feasibility and usability. Any thoughts there?

Male: So, from a feasibility standpoint with most system having EHRs and being how a functional topic. All this data components are tracked. I think some of the issues been discussed on the call today of missing data and kind of some data that maybe isn't in a place that it can be extracted easily. But I think all the data component should be documented. And so from a feasibility standpoint (felt) that even, you know, across multiple health systems that the documentation piece was there that maybe how it's extracted is different. But those key pieces could be feasible.

Reva Winkler: Comments from anybody else?

Thomas James: This is Tom James, and this maybe off in a different direction, but to me, the real – this one is or the mature level of this would be a patient reported outcomes measure. We've had discussion of that at some of the other workgroups and being able to move and some of the measure that are requiring physician documentation of patient's symptoms to primary documentation by the patient in the patient record outcome instrument. And I think it married the two of them up, that would really be something.

Reva Winkler: Think we could capture that as a recommendation through the overall portfolio, thoughts from anybody else? OK the last criterion is usability and use. Joel what do think?

Joel Marrs: I guess – and so from a usability standpoint, I think we talked about performance as low. And it could be from a variety of reasons and probably not necessarily completely because of lack of documentation but maybe some of the extraction piece. But I think, I think from a performance standpoint, it can be usable to highlight the need for improve documentation or improved systems to help show increase preformed.

Reva Winkler: Thoughts from any of the other work group members? OK, anything before we finish up on this measure and move on to the last one? No, OK then let's moved on to the last measure it's also a new measure. This is measure 2455, Heart Failure Post Discharge Appointment for Heart Failure Patients. Jason, I think this one yours?

Jason Spangler: Sure, thank you. Sorry, I'm just pulling up my notes here. So this is basically a heart failure – I would characterize as a readmission measure I mean to prevent readmissions through post-charge – post discharge appointment for those patients. On my notes, I had a concern when I came to the evidence because there's evidence for discharge planning, case management interventions and care transitions that reduces readmission for hearth failure. But I didn't see any evidence for just that one element, the post-discharge schedule follow up appointment.

Or even an actual – not even an appointment, but actually – I didn't see any evidence of an actual follow up visit actually reducing CHF readmissions. So I actually characterized that as insufficient evidence. Just – I mean there's some evidence that a combination or some things worked. But this specific post-discharge appointment that's scheduled, I didn't see any evidence for that.

Reva Winkler: So – Thomas James, you were the second on this one. Thought from you?

Thomas James: Yes I'm going to take the contrary point of view because that's the way I usually am. I think this been – some of the literature, the meta-analysis from (Philip). And there's a (Cochran) study that I found. It does demonstrate that those people who have greater contact with the healthcare system tend to do better and have a lower readmission rate. Now, it's not as specific as this. This – this quantifies it a little bit more than what I've seen in the literature.

And certainly from working within the insurance industry, we see this all the time that those people who have more contact are less likely to be readmitted. But that's an association not necessarily a (causation). And then in my own clinical experience points the same way that everyone in Kentucky likes to eat salt – lots of salt, anyway.

Firstly, I like the – I thought there was sufficient evidence to move this one forward.

Reva Winkler: Thoughts from anybody else.

Male: So I – I just have a question about that – that was stuff that you found on your own?

Thomas James: Well one of them was reference there. The (Philip's) articles was – was buried in the citation. The other I did my …

Male: OK.

Thomas James: … literature research.

Reva Winkler: Thoughts from anybody else on evidence? All right, Jason what are your thoughts on opportunity from improvement?

Jason Spangler: Yes, I mean it seems – the evidence that they probably – I mean there seem to be a considerable performance gap. Just looking at the mean was less than 50 percent have any sort of follow up appointment post-discharge. And they also provided evidence of definitive disparities exists across the different races. Also, I thought it was interesting the disparities between Medicare and Medicaid patients. So overall, I thought there was pretty high performance gap.

Reva Winkler: Tom and from you? Anything from anybody else? All right anything before we move on to the criteria for scientific acceptability? All right. Jason what do you think about the specification and validity testing?

Jason Spangler: So (forget) that – just again I think we probably don't need to reiterate this but I'll just say it again that this is a high priority just like everything else we'd

talked about with CHF. But I thought the measure specifications were pretty well-defined. I thought their algorithm was good. They had exclusions which I thought we're detailed well. But it was interesting, they also had exceptions which were different than the exclusion which I hadn't really seen before. But I thought those interesting as well. So I thought that this – I thought that the specifications were pretty good.

Reva Winkler: OK, thoughts – Tom, thoughts from you.

Thomas James: You know, after starting off disagreeing, I now am in complete agreement.

Jason Spangler: Tom, I'll say something really abnormal and then you can disagree with me.

Thomas James: Go back the old way.

Reva Winkler: Thoughts from any other work group members on the specifications? OK. How about the reliability and validity testing, Jason?

Jason Spangler: On reliability, I thought they did good reliability testing. And the results showed pretty high reliability. So, I thought that was pretty good. When it came to validity, you know, they did both face and content of validity. The (facility) showed a large percentage, you know, believe that – that there was good validity there so, you know, overall I thought it was probably moderate to high validity.

Reva Winkler: OK, Tom how about you?

Thomas James: You know, I would agree on that. When you start – when you start getting into some this statistical analysis, that's where I always leave it to somebody else. So I have to admit that.

Reva Winkler: OK. The rest of validity, you'd – you'd start talking a little bit about the exclusions and exceptions, anything further in that area?

Jason Spangler: I don't think so. I mean I thought that they – they did a pretty good analysis of the exclusions. I thought their explanation of the exceptions and how that was different made sense to me so I didn't see any apparent threats or any problems.

Reva Winkler: OK, anybody else on – on the work group? OK, this measure is collected through the Get with the Guidelines registry. From a feasibility perspective, how many – what's the level of participation in that registry among hospital? You may from the measure developer.

Robert Bonow: Bob Bonow here. That's a very good question, I don't have my homework on that one about the speed. I don't know if anyone from AHA is on the call. We certainly have good data as to the large number of hospital, there's million of patient records. I'm not just sure of the number of hospitals that are participating. And what percentage that is but this is obviously the – the data we've used to test this measure.

Ileana Pina: And it's a growing of registry that we're trying to steward as best as we can from Get with the Guidelines. I would say demonstrate hospitals that are committed to doing this. The point of transitions of care is very detailed in the new ACCHA guidelines, and really critical to the total communication of the patient.

As we go on I'm going to try to find those numbers for you. I have them somewhere.

Reva Winker: Jason, did you have it? I didn't mean to jump in front of you.

Jason Spangler: No, no. That was a good question and I know the answer to that, I mean I – yes I didn't have any problem, just, you know, there was – it's noted by the staff which are agreeing now, the abstraction is not done by, you know, the same person but, you know, it is a patient registry, there is data in the, you know, in electronic form as well.

So I thought the feasibility was OK.

Reva Winker: Thoughts from anybody else? Just – this is Reva, just one thing to think about with so many of the different registry measures are as part of feasibility are the cost associated with participating in these registries for the various providers.

Jason Spangler: So that would be under this describe any fees, license or other requirements?

Reva Winkler: Yes.

Jason Spangler: OK. Which they note that there is proprietary coding in some of the measure specifications, so they need to do – to get license but it doesn't have cost in there.

Reva Winkler: I guess, you know, I've seen where – there is in some of the measures, a description of a cost of the different registries. And perhaps somebody from ACC could just comment on that. I know we've talk about several different registries through the course of all these measures.

(Laura Paters): Hi this is (Laura Paters) from the ACC. I apologize, which registry specifically are you inquiring about?

Reva Winkler: Well this one is Get with the Guidelines for the heart failure management measures but earlier we were looking at PINNACLE.

(Laura Paters): OK. I can not speak to the Get with the Guidelines from American Heart Association Program. For the PINNACLE registry, there is no charge for participation to submit data and get the benchmarking. If we do primarily extract that data out of eMR system, there may occasionally be a cost associated at the site level for the initial mapping, but those are the only cost we're aware of that are associated with participation.

Reva Winkler: OK, thank you.

Ted Gibbons: This is Ted Gibbons. My recollection that to enroll in the Get with the Guidelines Heart Failure cost $25,000 per institution.

Reva Winkler: It would be probably be useful to verify that …

Ted Gibbons: Yes, I don't mean to pull that out of my head but I remember doing it before. So it may have gone up since I last looked at the cost.

Sam Tierney: Dr. Winkler, this is Sam Tierney with the (inaudible).

Reva Winkler: Oh, hi, Sam.

Sam Tierney: Hi, how are you? I just wanted to also add in the context of this discussion, although the information that we collectively submitted comes from the registry for the testing and the specifications, the measures can also be used outside the registry. The specifications are kind of universal enough that they could be used in other settings as well.

So just want to keep that in mind I guess as we think about these measures and any sort of potential limitations based on fees from the registry, I think that the measures can certainly be used beyond that context.

Reva Winkler: Right. Although I will point out that from NQF's perspective in terms of the endorsement, it really applies to the specifications for which the measures been tested and since they have been tested in the registry, that's what we'll focus on.

So, anything else on feasibility from the workgroup? All right. How about usability, Jason?

Jason Spangler: So it's currently using two programs, the only issue for me with usability is neither are publicly reported. They do have a plan for public reporting and that would be including this in the PQRS system within Medicare. But they didn't give a timeframe. You know, it seems like according to the criteria here that, you know, it would have to be within six years.

And I think – I would be confident that would probably happen if they're going to, you know, start now, trying to get that within PQRS. So I thought the usability was, you know, and this was probably pretty high as long as, you know, they would continue with their plan of getting public reporting.

Reva Winkler: OK. Thoughts from anybody else? Tom?

Thomas James: Yes. What struck me with this one was why is this one not available for use by health plans? As I look over the numerator, denominator specifications, it looks like this is something that I can obtain now out of that kind of data set

and could be use there for as a measure of accountability for health plans as well as for health system?

Jason Spangler: So are you saying that it should also maybe be like a HEDIS measure? That or …

Thomas James: Not necessarily adapted by NCQA but if NQF took it to the MAP or and go through that route …

Jason Spangler: Yes.

Thomas James: … is that an – uses in accountability measures for health plans. You can hold my …

Reva Winkler: I think, Tom what you're suggesting is that either an expansion of this measure or another measure that would similarly use the kind of data sources and level of analysis that the health plan would be very usable for you.

Thomas James: Absolutely.

Reva Winkler: OK.

Ted Gibbons: Reva, this is Ted again. How does this – I was just thinking about harmonization with other measures, for instance. The measure that we came up with or that was composite measures several years ago looking at readmission after initial hospitalization for heart failure, looking at whether there was an emergency room visit or primary care visit before or after readmission. It seems that there is a potential to harmonize this kind of measure with that.

Reva Winkler: Ted, let me just jump in there. CMS has retired those measures specifically and are I think – my understanding is they're taking – they're going to redo something along that line. And I don't know specifically what they're doing. But we don't have those measures anymore to worry about the specific harmonization at this point in time.

Ted Gibbons: Right. But it does address a similar issue about the optimal care and follow up after a hospitalization.

Reva Winkler: Absolutely. OK.

Female: Can I add one more thing? Just so you know, and get with the Guidelines, we have now constructed a new form for a 30 day follow up that includes if the patient indeed was seen within the first seven to 10 days from discharge as is in our paper by (Hernandez).

So in the future, we're going to have more information about the impact of that visit because we are collecting more information.

Reva Winkler: Look forward to seeing that. OK, Jason is there anything else about this measure you wanted to talk about?

Jason Spangler: I don't think so. I think we covered everything. Thanks.

Reva Winkler: OK. Tom how about you?

Thomas James: No, I'm just keeping people away from the salt lakes in Kentucky.

Reva Winkler: OK. All right. So we got through all four measures. Was there anything anybody felt we overlooked or blew by too quickly that they wanted to revisit because we do have the time? OK, if not, then we do want to have the opportunity for public comment. I believe all the lines are open. So is there anybody in our audience that would like offer any comments after question or anything before we conclude today?

OK, I'm not hearing anything. Sing out if you got something you want to say. If not, then our next step will be to convene in-person in April at the NQF offices to do the final evaluation of all of the measures for this topic area. I think everybody has the information for that in-person meeting and I'll look forward to seeing you all there.

To our measure developers who've joined us today, thank you very, very much for your time and your input. We look forward to continuing to work with you as we evaluate these measures. So if there's anybody have any questions about the next steps or anything before we finish?

OK, well, it's snowing in Washington, so I don't know wherever you may be but I hope your weather is better than ours. And with that I think we're finished for today. And we'll look forward to seeing you all next month in Washington. So thank you all very, very much for your time.

Female: Thank you for allowing us …

Male: Thank you.

Male: Thank you.

Female: Thank you.

Male: Thank you.

Male: Thank you.

Female: Thank you.

END