NATIONAL QUALITY FORUM

Moderator: Karen Johnson
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12:00 p.m. ET

(Shawn Bittorie): Good afternoon and welcome to today's Cardiovascular Maintenance Endorsement Project Standard Committee Call.

Please note committee members will have an open line for the duration of today's call, so please use your mute button when you are not speaking or presenting to reduce background noise. Please make sure your computer speakers are turned down or off if you're joining us on the phone, and please do not place the call on hold.

And now it is my pleasure to welcome you to today's meeting, let's get started.

Wunmi Isijola: Thank you, (Shawn). Good afternoon everyone and thank you again for dialing in for the post meeting call. I know we have several key items that we want to get underway.

Before I begin I just wanted to introduce our staff here at NQF. My name is Wunmi Isijola, Project Manager here; we have Lindsey Tighe, the Senior Project Manager; we have Vy Luong, our Project Analyst and we also have one of our Senior Directors Karen Johnson here on our side.

But before we get started, we just want to take a roll call of the committee members who are currently on the line. So Vy could you start off first.

Vy Luong: Good morning, everyone. I'm going to start up the roll call now with Mary George.

Mary George: Here.

Vy Luong: Thomas Kottke?

Thomas Kottke: Here.

Vy Luong: Sana Al-Khatib.

Sana Al-Khatib: I'm on the call.

Vy Luong: Thank you. Carol Allred?

Carol Allred: I'm here.

Vy Luong: Thank you. Linda Briggs?

Linda Briggs: Here.

Vy Luong: Jeffrey Burton? Leslie Cho?

Leslie Cho: Here.

Vy Luong: Joseph Cleveland?

Joseph Cleveland: Present.

Vy Luong: Thank you. Michael Crouch?

Michael Crouch: Here.

Vy Luong: Elizabeth DeLong? Ted Gibbons?

Ted Gibbons: On the call.

Vy Luong: Thank you. Ellen Hillegass?

Ellen Hillegas: Here.

Vy Luong: Thank you. Judd Hollander?

Judd Hollander: Yes.

Vy Luong: Thanks. Thomas James?

Thomas James: I'm here.

Vy Luong: Thank you. Joel Marrs?

Joel Marrs: Here.

Vy Luong: Thanks. Kristi Mitchell? George Philippides?

George Philippides: Here.

Vy Luong: Thank you. Nick said he will not be attending the call. Jason Spangler?

Jason Spangler: Here.

Vy Luong: Christine Stearns?

Christine Stearns: Here.

Vy Luong: Thank you. Henry Ting? And Mark Valentine will not be joining us today and Mladen Vidovich?

Mladen Vidovich: I'm here. Present.

Vy Luong: Thank you.

Wunmi Isijola: Is there anyone who we didn't call or was not able to state their (group)? OK. OK, with that being said, we do have a few measures that we'll be speaking to today. I know we had the follow up from the developers, but before we get started if in fact as a committee you would like to re-vote, you did receive voting instructions on how to do that, but in that case (Shawn) could you speak to the voting instructions? If in fact the committee decides to vote.

(Shawn Bittorie): Absolutely. Thank you so much.

Everyone should have received a link to enter the meeting today to ensure that you have voting privileges. If for some reason you did not use that link, don't worry we are also tracking in the background. When a voting question appears on your screen, you will see boxes to the side of each one of the choices. You will simply click in the box next to the answer of your choice. If for some reason you do not see those boxes, please try to refresh your session by pressing F5 on your keyboard or command R for a Mac.

Again, when these questions appear on the screen they are for voting members only and we will be tracking the votes in real time to make sure they have been calculated and your information will be stored in the report so we do know who voted what.

Back to you, Wunmi.

Wunmi Isijola: Thank you. And if you do have questions, we do have the chatbox available so you can definitely use that as kind of your troubleshooting. So we're going to get right into the measure 0643, Cardiac Rehabilitation Patient Referral from an Outpatient Setting, I know that …

(Shawn Bittorie): And Wunmi, I just want to step in and remind the audience one last time, if anyone has joined us on a tablet, you won't see the voting options on the tablet. You would need to be on a P.C. or a Mac.

Wunmi Isijola: OK.

(Shawn Bittorie): Sorry. Back to you.

Wunmi Isijola: Thank you. Do we have any of the developers from ACC?

Female: (Amy), do they have open lines?

(Shawn Bittorie): Would you like all lines opened or?

Wunmi Isijola: Yes, certainly.

(Shawn Bittorie): OK.

Thomas Kottke: This is Tom Kottke, I'm obviously not the developer but if I – while we're waiting for them. I think this can be quick. If people recall where we choked on this – they proposed that stable angina be a criterion for a cardiac rehab and we said, "Well, gee, it doesn't seem to us that somebody should go through cardiac rehab on a yearly basis for stable angina," and then they have the words increasing, what's this, stable increasing or new angina and it was an oxymoron, you know, it can't be stable and increase, either stable and do at the same time.

And so they have corrected the wording which I think satisfies our – and they just knew or worst they mentioned that does not need the criteria for unstable angina. And so I'm satisfied with that and that was the only, let me say hiccup in the whole thing, the cardiac rehab clearly reduces mortality but referral rates are very low and – unless people refer we don't know where the next road block and the cascade to complete cardiac rehab.

Wunmi Isijola: OK. Will there any other discussion around that?

Leslie Cho: My only concern, this is Leslie Cho, my only concern is as I stated before, I worry about, you know, having physicians – I know Tom is going to disagree, but having physician be held accountable for inpatient and now the outpatient. And I realized the indication is more of a hospital measure and the outpatient is more of a physician measure. But to me in my mind, there is no clear way if one person gets an, you know, an M.I., gets referred from cardiac rehab as an inpatient and then somehow goes to their outpatient doctor and their doctor doesn't check off the cardiac rehab that outpatient doctor gets in. Then I just feel like if – we're asking physician, you know, for the same patient to be dinged twice, that two (encatchment), I think that's a little too much.

Wunmi Isijola: Are the lines open that the developers can comment on that.

Randy Thomas: Hello, this is Randy Thomas can you hear me?

Wunmi Isijola: Yes.

Thomas Kottke: Yes.

Randy Thomas: Oh, you can hear me now? OK. Great. So, yes, so we're all trying to chime in, but I think our lines were not opened.

Female: Sorry about that.

Randy Thomas: Yes. And thanks Tom and Leslie for your comments. The – As Tom mentioned, our group submitted a revision to the wording of the criterion for the stable angina and we really appreciate the input because I think this has made it a stronger statement and measure now. And as Tom mentioned we've recommended revising the wording to include new or worsening symptoms that do not meet criteria for unstable angina just to make it more clear. We borrowed this from the wording from the ACC/AHA Guidelines for the stable ischemic cardiac disease. And I think we sent along the link to the guidelines in their Class I indication for cardiac rehab. So – And that's on that front.

And Leslie I'd like to address your concern too. Can you – I want to make sure I'm understanding you correctly, your concern is that, you know, it'd be too much to expect the physicians to refer from the outpatient setting?

Leslie Cho: No, if a patient – if one patient, let's say me. I have a heart attack and I go to the hospital and they referred me inpatient measures. This is (043) which passed, OK? I got referred for cardiac rehab.

Randy Thomas: Yes.

Leslie Cho: If I then show up to my outpatient physician's office and my outpatient physician does not refer me in the notes because he was running late or he was busy or whatever, I've already been referred mind you, that patient – that physician gets dinged. I've been referred, you see, from inpatient.

Randy Thomas: Yes. So good question.

Leslie Cho: Because you're taking two different database. What is the PINNACLE Registry database which is an outpatient registry database, right? One is the NCDR database.

Randy Thomas: I'm not sure quite to follow the database question, but getting back to the original question, the – so if a patient is – patient has an M.I. in the hospital, they are referred to rehabilitation. The outpatient physician is not going to be held responsible for referring them because they've already been referred. The only that will happen is that patient when they come in for an outpatient visit, it should be noted in the record if they have attended rehabilitation or not. If they have, then the measure specifies that that patient is no longer (so to speak) and they're not in the nominator. If the patient has not been referred then that outpatient physician is responsible for offering them.

Marjorie King: And this Marjorie King another measure developer in practice, in private practice which where I've worked, we've done similar things for smoking cessation where you have a place in the paper medical record or the electronic medical record if the patient is smoking yes, no so that, you know, whether you need to discuss it. A very similar data field could be set up in the outpatient record for has the patient gone to cardiac rehab yes, no. That does need to be done by the physician but could be done by the med tech putting a patient in the …

Leslie Cho: I know but the measure was developed using the PINNACLE Registry, correct?

Marjorie King: No, the measure was tested using the PINNACLE Registry.

Leslie Cho: Right, but in order for – so let's say – so what I'm saying is does the PINNACLE Registry and the NCDR Registry which measure (06 or two is off of) do not necessarily talk to each other, right?

Marjorie King: But physicians and the nurses who put the patients in the room for an evaluation or an exam and the patients all talk to each other. So that's how the information …

Leslie Cho: But I feel like it's – I don't know if to me it seems a little redundant to hold a physician responsible when this particular – like this now that the, you know, the chronic whatever (is done) you basically have an M.I., PCI, and a CABG patient being referred to the bypass. Now, all of these patients will be referred hopefully in the inpatient setting. So the patients that were not referred in the

inpatient setting is really the people you're trying to catch. It's in that to over measure for the people that we meet somehow on 0642.

(Crosstalk)

Male: How many of them are going to see – (it's like when) I was down there in person, hi everybody. (Some) of that are going to be new to the outpatient physician, some of them are going to be caught that's correct.

Leslie Cho: I mean, I just think that so if this outpatient goes to – I understand, listen I am all for cardiac rehab. I want a cardiac rehab improvement, but my worry about something like this is when you keep on having sort of the same thing and you keep on asking physicians to do more thing, more thing it's just a lot of I don't know there's a lot of I think there's measure overload a little bit.

Randy Thomas: Maybe a …

Leslie Cho: I think one of the things we should also try to do is try to institute quality, but also try to do it such a way it's easy and doable for physicians and whatnot.

Thomas Kottke: Can I jump in here, this Tom Kottke.

Leslie Cho: So if an out patient was up to inpatient did get discharged from the inpatient and goes to a cardiology office that's when (clinical) to medicine office neither of them says cardiac rehab who gets dinged?

Thomas Kottke: Can I – I want to jump in here, Tom Kottke, you know, last at the Washington session we voted on a measure that would require primary care physicians to fill out or have their patient fill out a question here that has no documented relationship to outcomes. And I think given the gap in cardiac rehab and the impact on outcomes they're asking cardiologist or other doctors to simply document that they asked a patient if they had been referred to cardiac rehab is not burdensome. And I think we are to call the question in vote because we're just going back and forth in this thing between Leslie and the proposers.

Wunmi Isijola: Thank you Tom. Are there are any discussion around it before we go ahead and get in to voting?

Henry Ting: This is Henry Ting and I'm sorry I joined late, but just so I can be clear my own mind before I vote. Is the performance of this measure meeting compliance or defect? Someone referred for cutting rehab or not. Is this already as (Phil Beryl) spoke before and he pointed out already captured in the inpatient performance measure and this would essentially capture the same defect under a compliance? Or is it a separate measure that captures something different?

Thomas Kottke: Well, for patients who weren't treated in the inpatient it captures them.

Henry Ting: OK.

Thomas Kottke: And we're starting – STEMI it says is 24-hour admission, so I can see in the next year or two that we treat STEMIs as outpatients.

Henry Ting: I would beg to disagree with that statement but – so do the only patients this will capture would be outpatients who have PCI, who have PCI like that in the hospital and outpatients who have their heart attack at home.

Randy Thomas: So the outpatients who have stable angina and not really may an outpatient that's already captured outpatient with PCI as well and then those who were not captured in the inpatient setting for any other indications.

Henry Ting: So and …

Marjorie King: It's the inpatient population should be captured in an outpatient setting as opposed to an inpatient setting.

Henry Ting: Right because any – all these procedures and major two coronary (serum) diagnosis are inpatient they're not done as an outpatient. And when they are maybe we consider performance measure in the outpatient setting as we suggested that we would treat STEMI in the outpatient. But for the outpatient I thought our discussion in Washington D.C. was patient with stable angina, the clinic stable angina patients would need referral to cardiac rehabilitation.

Thomas Kottke: Yes, but we don't have chronic, they've changed the word Henry. They do for increasing angina that does not meet the criterion of unstable. So a stable angina Randy needs to …

Henry Ting: So that was the major point we had in Washington D.C. because that's a group they have just – for the inpatient and we will need to clarify who make that discretion that angina has changed.

Thomas Kottke: Henry you're not treating a particular patient. I mean, you're just setting the criteria, you know, it's in the note I mean we take the doctors note all the time even for diagnosis.

Henry Ting: Right, so everybody with stable angina has to have a cardiac rehab referral within 12 months, is that what they measuring?

Thomas Kottke: Stable angina is not in the measure anymore. It's new or increasing angina that is not – does not meet the criteria of (inaudible).

Female: So this is going to.

Thomas Kottke: So it's new or increasing.

Henry Ting: So how do we diagnose that? How do we make that, this is the denominator, Tom. How do you actually other than …

Thomas Kottke: OK, what the doctor writes down that means to say why you make the diagnosis of unstable angina the doctor writes down, patient has unstable angina where you say, oh OK patient has unstable angina. I mean, how do you make the diagnosis of angina anyway. And so it's a very subjective.

Henry Ting: Yes, exactly, I said why – it's very of who is in the numerator and the denominator there.

Wunmi Isijola: Yes and just to chime here …

Thomas Kottke: So it's up to the doctor to write it down.

Henry Ting: Right. I agree, I completely agree with you Tom.

(Sena Olgative): Can I ask you a couple of questions? This is (Sena Olgative). So if I remember correctly part – at least part of the utilization of this measure is you would be using administrative claims data and there's not a way to distinguish stable angina from – an unstable angina from this new definition that you're using. The other thing that I would add is assuming that we're able to find these patients, do you have a sense of the magnitude or the size of the patient population that would fulfill this measure, I mean this description because that's really ties in very closely with the impact, the potential impact of this measure. What is the size of this population who don't have stable angina or unstable angina but somewhat in between?

Randy Thomas: Well, this is Randy Thomas. What I can say I don't have all the information to answer all of your questions but I'd say that it is very clear that right now of all the patients who are seen in the inpatient setting, we'll talk about stable angina in a second, all the patients in the inpatient setting have had an event that qualifies them for cardiac rehabilitation somewhere between 60 and 80 percent are referred and somewhere between 30 and 40 percent actually enrolled in cardiac rehabilitation.

So if you're looking anything gap just go to the problem if it really gone over to as for the stable angina patients there's not very much data that's been published on stable angina and referral to rehabilitation or enrollment but the – most of the gap information is available for the patients who've had a procedural and M.I. related indications.

Wunmi Isijola: OK. And with that being said, do we want to go ahead and vote? And this is based on the rewording of the specs that the developer presented?

(Christina): Before we vote this is (Christina), (Joy), I have one quick question. Can you remind me, is this measure currently in use with this?

(Joy): Yes. This measure currently in use.

Randy Thomas: I'm sorry. I couldn't here you at all. You're asking if it's been …

(Christina): Yes.

Randy Thomas: … if the measure is in use currently?

(Christina): Yes.

Randy Thomas: Yes. The measure is in use in the clinical outpatient registry from NCDR. And it had been used in various centers around the country as well but it's – a primary use in the registry is going to go. It's also being used in the PQRS program for CMS.

(Christina): Including – it's being used by PQRS. Thank you.

Wunmi Isijola: Are there any other comments before we move on with the voting? OK. And with that being said.

Female: Given the new information presented I just – (voices) in the Committee, do you wish to revote or do you wish to maintain your original vote.

(Crosstalk)

Female: OK.

Female: OK.

Henry Ting: I'm sorry. How are we supposed to vote?

Lindsey Tighe: Through the webinar, you have the option to vote. So, go ahead and get to the first (topic).

(Off-mike)

Male: Oh, OK.

(Shawn Bittorie): So the voting side it's currently shown on your screen. You'll see some empty boxes next to your choice A and B. Simply click in the box next to the answer of your choice and your votes will be recorded.

Lindsey Tighe: This measure passed importance during the in-person meeting of the material (seems) the developer submitted really (went straight) into the scientific

acceptability of the measure. So, we'll ask you – we'll maintain the importance of – to the in-person meeting and start voting on scientific acceptability and reliability. And the voting (has) start.

Henry Ting: Are we voting on the inpatient measure right now?

Wunmi Isijola: We're voting on the Cardiac Rehabilitation Patient Referral from Outpatient Setting.

Henry Ting: OK.

Lindsey Tighe: OK. And you can begin voting on Q.A. reliability.

Male: I feel like I should point my mouse to the …

Female: OK.

Female: Yes.

(Off-mike)

Male: OK.

Lindsey Tighe: OK. We're going to stop voting in just another second. So please leave your votes (to the left).

Female: OK.

Female: OK.

Female: OK.

Lindsey Tighe: OK. So we have six have voted high. We have one that voted high. Oh, I'm sorry. We have one that voted high. 10 that voted moderate and five that voted for low, two (got) voted for insufficient for criteria to a reliability, OK.

Wunmi Isijola: And we move forward.

Lindsey Tighe: So we'll move forward and vote on 2B, validity.

Wunmi Isijola: Validity. And the voting can start now.

Lindsey Tighe: OK. So, right now we have one for high, two – nine for moderate, six for low, and two for insufficient for criteria 2B on validity.

Wunmi Isijola: So we will move forward.

Lindsey Tighe: OK. Because the measure was voted down at validity during the in-person meeting, we have not had a discussion of feasibility. Certainly other than what was just discussed now. Tom, do you have any comments to make about feasibility at 643?

Thomas Kottke: Yes. I mean – it prefers certain people with electronic health record that have a field it will be – they'll be able to pull out an electronically otherwise it will require chart view. But there's seems to be no problem for me with the – about feasibility.

Lindsey Tighe: All right. Any other comments from the committee members or Carol?

Jason Spangler: This is Jason. I have a question to the – about the validity vote.

Lindsey Tighe: Yes.

Jason Spangler: I thought it was between the 40 and 60 percent range.

Lindsey Tighe: It was, it was consensus not reached. But we will continue moving forward …

Jason Spangler: OK.

Lindsey Tighe: … with the measure.

Jason Spangler: Got it. Thanks.

Lindsey Tighe: Any other comments about feasibility?

Leslie Cho: I have a question, it's Leslie Cho. Can you do this without a PINNACLE Registry? Can you – can the physicians if they're not part of PINNACLE or do they have to (abide) PINNACLE in order to have this?

Randy Thomas: Absolutely. They can do without PINNACLE. (We are) testing (within, without) PINNACLE. We identified centers from PINNACLE and other centers that participated in the feasibility and reliability testing.

Leslie Cho: How would you – how would they use it outside PINNACLE and be able to capture the data that you need for the measure?

Marjorie King: On chart reviews like …

Randy Thomas: Yes.

Marjorie King: … as we tested it. It was paper charts, it was chart reviews that was similar to how you would test the measure for something like smoking cessation, aspirin use to other things that – you can use these measures outside the registries.

Leslie Cho: Well, but they had to be electronically specified. Electronically used, I mean, that's one of our, you know, required within NQF. So – if you're …

Male: No.

Leslie Cho: … if you don't have access to a registry, how are you going to do …

(Crosstalk)

Marjorie King: If that in fact true that's for all (your) current measure specs, everything has to be electronically specified?

Leslie Cho: Driving at that way. But I'll let the NQF people address that.

Randy Thomas: All I can say is from the specification side, the – we are in the process of working through specification. And have been working on this but that's not part of the submission for this current endorsement that's a separate process that we're working on. So, and I would say that my goal is to have

specification available not just in PINNACLE reason in any of the vendors that have electronic medical records.

Thomas Kottke: Tom Kottke here. I think, and the only electronic – there's only one electronic measure in the cardiovascular portfolio. But I'd like to hear from NQF about that. Because they made a big deal out of that when you're in Washington. This could be a (hybrid) measure, and it's going to require a chart review.

(Crosstalk)

Henry Ting: Hi Randy, this is Henry. And can you help maybe explain the measure specification of how you plan to standardize or instruct physicians and cardiologists to categorize what is stable angina and what is not stable angina and how that would be, you know, some standard across cardiologist in practices?

Randy Thomas: So, we use the same criteria that were published in the ACC/AHA headlined for stable ischemic heart disease, that's where I got the wording from. You know I think we've attached the reference for anybody who'd like to see that. So it's – yes. I have met with you and with Tom and others to just like many parts in medicine is not an exact science. But it's to identify the denominator is simply looking at those patients who are designated by the physician as having an episode stable angina. Oh, I'm sorry, a new sort of angina that meet those criteria. So, I admit medicine not a perfect science. But, that's what we went by the standard as published in the ACC/AHA guidelines.

Henry Ting: And maybe as part of – (in case) that I haven't read those guidelines and don't have to (let the) tip of my tongue. But, can you just remind us, what is not stable angina in terms of the change and duration, frequency or pattern? How much of it would it be – for a patient for me to categorize. This is not stable angina, just maybe a high level.

Thomas Kottke: It's – that's not in the guideline.

Randy Thomas: Yes.

(Crosstalk)

Thomas Kottke: If you decide – if you wrote, you know, you saw a patient you say, yes new angina and – but it's not unstable. I'm not going to send them off to angiography. Nor it is angina is a little worst or it's increasing any of those words. I mean it's …

(Crosstalk)

Thomas Kottke: … heart failure, you know, Class II heart failure what's Class II heart failure.

Judd Hollander: So this is Judd and this is sort of my area of research although I'll be in the emergency department and not cardiac rehab and I could tell that nowhere in the world is there a definition of angina that's reliable and reproducible or unstable angina for that matter because it assumes the clinician could tell what pain and what symptoms is cardiac versus not cardiac using clinical judgment alone.

And so to me it would seem the standard of care is if you believe somebody has unstable angina and they're in the outpatient setting that patient shouldn't be going home they should be going to the inpatient setting by definition. And so if you're not just looking of what happened following a hospitalization there really shouldn't be situations were the outpatient doc in their office practice is seeing new unstable angina STEMIs or NSTEMIs.

Thomas Kottke: Yes, Judd this isn't about unstable in fact the wording says it specifically about new or worst mean angina that does not meet the criteria of (having). So this doesn't have anything to do with unstable angina. I agree with you 100 percent unstable angina they're going to hospital, but this isn't about unstable angina.

Judd Hollander: Right, but I think by definition I'll be – like I said there's no real definition new or progressive angina is what gets called unstable angina.

Thomas Kottke: Not all the time.

Female: But there's not – I actually have serious concerns about the feasibility of this measure in terms of really capturing that patient population that falls between

the stable angina and the unstable angina having been a cardiologist now for almost 14 years. And I know these guidelines that you're referring to are more recent I am not yet to see one note from a cardiologist that says all the patient does not have stable angina and does not have unstable angina but they fall in the middle. I just think that it's going to be impossible to define that patient population.

Male: And I'm doing in that epidemiological study.

Marjorie King: Yes, I don't know if the measure developers are allowed to speak or not right now. But I just, this is Marjorie King, I'd like to remind you that this measure is not just for unstable angina that was just, I'm sorry excuse me, this measure was not just for stable angina but it really was developed for patients with post bypass M.I., PCI, transplant all the things that are without surgery, all the things that the inpatient referral measure was developed for.

But this stable versus unstable angina is just sort of a side issue. If this measure has been through approval this is the third time now that it's been to an NQF group. And we just, it just never hit us that stable angina wasn't well defined and that there maybe the potential for the expectation referral every year. But this measure is to catch those who fall through the cracks after their inpatient stay for when they see the doctors, for the doctor to just remind – remember to refer the patient to outpatient cardiac rehab. So, and I am sorry I talk too much but I feel pretty passionately to having been a cardiologist for 30 years about this.

Henry Ting: That would be fine Marjorie, but the biggest population in this numerator will be those with stable angina or not stable angina.

Marjorie King: No practically speaking and again were in the (net spot) in New York area we get the majority of our referrals from an – from the physician's offices not from the hospitals. And those are for all of those diagnoses not for stable anginas, so.

Henry Ting: Those diagnosis, but it just from the epidemiological standpoint there are more and more patients with stable or not stable angina than their …

Marjorie King: correct.

Henry Ting: … vascularization procedure, surgical or percutaneous.

Marjorie King: Correct, no I know with (recurrent angina).

Male: (They're not basing) the portion of patients.

Marjorie King: Right.

Male: I mean, that has nothing to do with the measure from the patient from each category.

Henry Ting: No, no but that's in the denominator and that's a very large portion of the denominator and that portion is so subjective I'm not sure what this measure will actually tell us when aside you reporting 80 percent or 40 percent in terms of its performance. Because if that – because they know how to diagnose not stable angina. Or they're not knowing how to – or is it really a gap in care that we're missing because we need to get patients to cardiac rehabilitation. Again I believe that cardiac rehabilitation very much as everyone else does.

Wunmi Isijola: And just to interject …

Male: We could ask same question about any procedure where you see a difference – tenfold difference in knee replacements, I mean.

Henry Ting: So we're not (talking) of any other procedure. We're talking about this measure and we should focus on this measure and access to heart failure or something else.

Wunmi Isijola: And just to interject we're just talking on the evident – the criteria of feasibility at this point in time. So if there aren't any discussion around feasibility we should just move forward to vote on that piece. If there aren't any questions or discussion surrounding that? OK, so let's move forward with voting on feasibility.

Voting begins now. OK, and this as an FYI this isn't a must pass criteria so (done with).

Lindsey Tighe: Yes, so we have one that voted high, five that voted for moderate, 11 that voted for low and two that voted for insufficient for the criteria on feasibility.

And so just to further explain when you comment. This is not one of our must pass criterion so we'll consider discussion of the measure and the use and usability of the measure. When we come to a final vote on the overall recommendation for endorsement we'll ask you to weigh the importance of the measure, the scientific acceptability, the feasibility and usability kind of all of together using your own personal weighing. Then come up with your overall recommendation for endorsement at that point in time.

So with that said Tom or Carol do you any comments on the use and usability of the measure?

Thomas Kottke: Well, I'm here. It seems usable to me, (I guess). That's I guess what I'll (put) that's the (URL) stick in the water. I don't think …

Lindsey Tighe: Carol?

Thomas Kottke: … there are unintended negative consequences.

Wunmi Isijola: OK.

Thomas Kottke: That are important.

Wunmi Isijola: Are there any discussion around usability and use?

Carol Allred: Can you hear me? This is Carol.

Wunmi Isijola: Yes.

Carol Allred: OK, my one concern about it was the ability, the difficulty for the physician to actually transmit the information. Because so many of them have different EMR's and not all of them talk to one another. That was my one concern.

Wunmi Isijola: Thank you Carol. Is there anyone else who want to weigh in?

Thomas Kottke: Yes, Tom here. But this isn't necessarily now an eMeasure.

Wunmi Isijola: OK, if there aren't any other comment we will move forward with voting on usability and use. Voting begins now.

Lindsey Tighe: OK, so for usability and use criteria. Two voted high, five voted moderate, nine voted low and two voted insufficient information.

Wunmi Isijola: Thank you.

Lindsey Tighe: OK.

Wunmi Isijola: So we will now vote on the overall recommendation for endorsement and as Lindsey mentioned if there are any discussion around the overall measure as it relates to the four different criteria that can take place now. If not we can move forward voting.

Female: I'm voting.

Wunmi Isijola: Is there any discussion Tom or Carol or any of the other committee members?

Thomas Kottke: I don't think there's new information.

Wunmi Isijola: OK.

George Philippides: I just had one voice (said) – one side of the argument because I think it's been important.

Wunmi Isijola: OK.

George Philippides: As a clinician who sends patients to cardiac rehab, I'm not confused at all by the issue of their definition of angina. I think all they're getting at is if a patient is really unstable requires advance care, you probably shouldn't send them to cardiac rehab. And while we don't have hard definitions for that I think most clinicians have a feel for that. That goes without saying.

So to me to not take this measure which could be important in getting a large group that aren't going because of that definition (fog) to me it's not a big

issue. So I just wanted to chime in with my two senses of just another clinician.

Wunmi Isijola: Thank you Henry.

Male: That was George.

Wunmi Isijola: Oh I'm sorry

Is there anyone else? OK, with that being said, we will vote on the overall suitability for endorsement, voting begins now.

Lindsey Tighe: So in conclusion, our overall suitability of endorsement eight voted yes and 11 voted no. OK, so 42 percent voted yes so it falls within our gray zone, so our consensus not reached. We will put the measure out as consensus not reached and solicit comments on this measure in particular from those who are commenting. Provide that information back to you all at the end of the comment period and have another discussion then.

Wunmi Isijola: Thank you. OK, and with that we will move forward with measure 2379 Adherence to Antiplatelet Therapy After Stent (Implementation). Do we have any of the developers from CMS on the line?

Kyle Campbell: Hello this is Kyle Campbell from FMQAI. Can you hear me OK?

Yes.

Kyle Campbell: OK, great, yes, I'm available.

Wunmi Isijola: OK, great. So if you want to just provide the findings that you presented to the committee.

Kyle Campbell: Sure. So at the Steering Committee meeting on April 21st in D.C. members had concerns about the inclusion of patients receiving bare metal stents without an acute coronary syndrome indication. And so based on those concerns we have revised the measure to exclude VMS procedures without an indication for ACS and we provided on May 2nd a memo that summarizes our

approach to the exclusion that suggested revisions to the measure specification which are in red text and the revised testing result.

And I can see that memo is up on the screen now and I would just ask if the committee would like me to walk through this memo or whether you prefer to just ask questions.

Wunmi Isijola: I think it would be good for you to walk through it. Thanks Kyle.

Kyle Campbell: OK, sure. So the first question or the first consideration is how would we identify bare metal stents versus drug-eluting stent in the administrative claims data. So we did a review of coding and you can see in the coding table the type of stent, the code system, and the code along with the description and we did have two cardiologists on our team review the codes. So the first five codes represent codes that identify bare metal stent and the next five codes represent codes that are used to identify drug-eluting stent.

We're also aware that starting in January 1st, 2013 that new CPT and HCPCS codes have been created for billing stent procedures and in the memo we have included those codes in the specification but for our test data set which look at claims between 2010 to 2012 these are the codes we use for – our stent identification. The second issue is that next you need to identify patients with an acute coronary syndrome and that was determined based on a presence of an ICD-9 code of either 410 or 411 any of the diagnostic code fills and part A or part B and the detail descriptions for that can also be found in the Appendix. And again those were reviewed by two cardiologists on our team.

The next issue that we considered was how to associate the acute coronary syndrome diagnosis with the stent claims and we did that through the date. So if the date of the acute coronary syndrome claim and covers the date of the same procedure then the ACS diagnosis was considered to be associated with the stent, otherwise, the stent was considered to be for a non-ACS indication and this is generally consistent with the identification of ACS diagnosis for stent procedures that we identified in the literature and there's a citation included.

So in summary how do we exclude bare metal stent placement for a non-ACS indication, essentially what we did was any claim that had a code listed on the table below in four without a corresponding ACS claim with that overlapping period were excluded from the data set. And number five then we looked at what the impact of the proposed exclusion on the measure rates and scientific acceptability were. So the proposed exclusion resulted in a decrease and approximately 13.6 percent of individuals in the measure denominator on our (10-state) sample. And for our ACO data sample about 12 percent. The mean measure rate increased about 0.01 to 0.02 across each level we measured and we still did have a gap in performance with the mean rate of approximately 0.78. Remembering that 0.8 is the critical threshold and you would expect that patients would be closer to one.

The variation and performance remains 0.06 to 0.14 between the 10th and 90th percentile across all levels that we measured and the reliability based on our (Cigna-Manois) analysis remains very high across all levels in measurement and that's included in Appendix B.

So for number six based on the review one of the final recommendation and conclusion for the Steering Committee, we recommend the revision to the specifications to add this exclusion that would remove these patients from the measure population and the proposed revision to the specifications are shown in red and so where you see the red text and that's where the measure specification have been revised. And so the revised measure description now essentially read average proportion of date covered for individuals with antiplatelet therapy during 12 months following implantation of a coronary artery drug-eluting stent regardless of the indication or bare metal stent for acute coronary syndrome.

And down at the bottom for the denominator exclusion, if you just scroll down and still outside my screen. I don't know if you can see it. Yes, the placement of the coronary artery bare metal stent for non-ACS indication are excluded and then we retained obviously our exclusion for individuals with contraindications to receiving antiplatelet therapy. And the two coding sets are here, the first Excel table just shows the revised codes in 2013 for bare

metal stent and drug-eluting stent. And the second table shows the ICD-9 codes along with the ICD-10 crosswalk to identify acute coronary syndrome.

And then if you scroll on basically we provided the committee with the revised testing result, the meaningful differences and performance so you can see the distribution at each of the level and then the last page – last couple of pages provide the revised reliability scores based on the new measure definition.

Wunmi Isijola: Thank you Kyle. Is there any discussion around the revised specification from the committee? OK.

Linda Briggs: This is Linda Briggs. I think that the people that proposed the measure did a really nice job of going back and making modifications to try to exclude a group of patients that we had concerns about, however, the biggest concern that we had was that this recommend – or this measure is not completely parallel and congruent with the recommendations for acute coronary syndrome patients. My point is that in the unstable angina non-STEMI guidelines while it does recommend that anyone that this unstable angina, non-STEMI with the PCI have a P2Y12 or greater than or equal to 12 months.

It also says particularly in the footnote there that if the risk of morbidity secondary to bleeding is greater than the benefits then early discontinuation should be considered and it's a 1C recommendation on page 221 of those guidelines. So, sometimes people interventionalist will choose bare metal stent specifically because people maybe anticipating surgery or they know that the patient has a history. And upfront you would catch those people in contraindications. But if someone develops a contraindication potentially during the time that the stents are being or the drugs are being given, I'm concerned about whether we're capturing that contraindication within that 12-month period. And also those people that again that you sort of planned that they don't really have a contraindication but maybe they have a surgery that's planned et cetera.

Wunmi Isijola: Any comments?

Judd Hollander: Yes, this is Judd, correct me if wrong and maybe I'm confusing the measures now that it's a couple of weeks later. But wasn't our concern on this measure large part related to whether it's actually adherence being measured? Or whether just different prescription plans may provide different coverage for the medications and it may have nothing to do with whether the patient actually takes them.

Linda Briggs: We did have a concern about adherence but one of the larger arguments was related to the fact that bare metal stents have a different recommendation than DES stents. The bare metal stents in every recommendation say up to 12 months. It doesn't say greater than or equal to 12 months as the drug-eluting stents do. So it's – people would still be – physicians would still be well within the guidelines to discontinue during that 12-month period or patients who have a bare metal stent. They would be fully within guidelines but they could get dinged based on the measurement in this particular measure.

Judd Hollander: Right. So I agree that that's true. But then I guess maybe I'm throwing out an additional concern for this conversation. And my concern is that if you happen to be in a prescription plan which of course your physician doesn't control what your pharmacy plan is, where every two months or three months they send you your drugs without you having to renew. You're going to be considered adherent whether or not you actually ever take the drugs.

And so those patients will do well but the physician doesn't control who those are. And if you need to go every month then pay for that out of your own pocket, while the physician can't get you the drugs if they cost money and you don't have money. So it's hard to say to say the physician is responsible for that.

It's one thing if you ask, does the physician write the prescription when you're seen. But to me this is going to be, you know, significantly driven by a patient's income and insurance plan. And the provider really doesn't control that at all.

Kyle Campbell: So this is Kyle Campbell for the measure developer again. Maybe the best thing to do would be to address the guideline issue first and then move to the

issue with regard to the way the measure and actually measures adherence. As far as the guideline goes, the guideline on page 25 from (online) basically outlines that patients with a bare metal stents or drug-eluting stent that have an ACS indication should be given the P2Y12 for at least 12 months. It extends for drug-eluting stents for non-ACS indications.

And then the third guideline is BMS for a non-ACS indication which is the population that we're excluding should be given for a minimum of one month and ideally up to 12 months. And what the committee – my understanding of what the committee asked us to do was to take out that population of patients receiving elective BMS such that we wouldn't be penalizing physicians or health plan if the drug was discontinued earlier than 12 months.

As far as the contraindication issue, the contraindication we look the entire 24-month measurement period. So you have a 12-month identification period to identify the index event for the stent. And then the following 12 months to look at the actual drug identification.

If a patient has a contraindication at any time during that 24-month period they are out of the measure denominator. So from that perspective, I do believe we are accounting for patients that will have any sort of (bleed) during the follow up period. In terms of the adherence question, this measure is consistent with all the other endorsed measures in the NQF portfolio that measure medication adherence. So we recognize that, the filling of claims is a proxy for adherence but it has shown to be a valid proxy in the literature.

We do concede that if the Stirring Committee feels strongly about the levels of measurement we are willing to drop the measurement at the physician group level and only retain the measure at the state – the accountable care organization and the health plan level.

Judd Hollander: So I would comment that I would strongly favor that because I think your health plan does determine whether you're going to get your medications. The individuals physicians may not or the physician groups may not. So I want to make sure we hold the correct people accountable.

Thomas James: This is Tom James speaking, one of those correct people being held accountable. I would agree with that although I do know as practicing physician that – when I ordered the most expensive drug people are less likely to fill it unless they've got top end insurance. So there are things that physicians can do in proper pharmaceutical selection. But it's still (I just want that) health plans should be held accountable for.

Wunmi Isijola: Are there any other comments with regard to the specs that were presented today? OK and with that being said we will …

Lindsey Tighe: OK. So because the developers (have then have the option) of either specifying the measure at the clinician group level and above or omitting that, we do need to clarify when we move into a vote what the committee is voting on. So is the measure without the level of analysis of the clinician group level or including the analysis that at clinician group level.

Linda Briggs: This is Linda I would proposed of this measure goes forward that it only be at the state NACO level not the individual provider level.

Lindsey Tighe: Is there any disagreement with that?

Judd Hollander: You may add health plan too.

Lindsey Tighe: Yes absolutely health plan also. Just ask some of the level of analysis at the clinician group level.

Judd Hollander: Right. I'd be happy with that.

Lindsey Tighe: OK. Hearing no disagreement we'll move forward with voting on the measure. Keeping in mind that we'll be voting for this – the lowest level of analysis will be at the individual health plan level and then with the exclusion related to be and they're all set and sight Kyle with details.

Male: Can I ask a question about this before we vote?

Lindsey Tighe: Sure.

Male: Is there any way to gather data on the individual level but only report it at the levels that are higher as you guys mentioned? Because I – let me give you just another side and I don't feel strongly about this. If I just had a patient of mine get a drug-eluting stent and I know that it's really important that they stay on Aspirin and Clopidogrel for 12 months. One of the most important things I do at their follow up visits is query them about Aspirin or Clopidogrel and try to get to the fact that they're not taking at their insurance company is no good and make every effort I can to help them.

That sort of why they're following up with me. It's one of the reasons. So it might be interesting to find out if within the same ACO or insurance group some clinicians are doing a better job of this than others. I wouldn't like it being reported but it might be interesting data. So I'm wondering if it can be gathered.

Kyle Campbell: So this is Kyle Campbell one of the measure developer again. Yes, its certainly can be gathered because it's all available in the administrative data. And likely if this measure were implemented at the ACO level or the health plan level part of the intervention, any quality improvement intervention that a health plan might undertake would involved, you know, the prescribing physician and providing, you know, data in that regard. So that they were aware of what the adherence, you know, for their patients were.

Male: I mean looking two years down the road it would be interesting if it turned out that within the same ACO some physicians had a very, very high rating and some very low that could not be explained by the other variables. So I'm glad to hear that.

Wunmi Isijola: OK. We'll move forward with the reliability voting. Voting begins now.

Lindsey Tighe: Oh, and for our criteria 2A voting results, two voted high, 15 voted moderate, zero voted low and one voted insufficient for reliability, OK.

Wunmi Isijola: We'll move forward with validity, if there are any discussion around that.

Lindsey Tighe: Other than what's already been said?

Wunmi Isijola: OK. So we'll move forward with the voting.

Lindsey Tighe: And the voting starts now.

So in conclusion, our criteria 2B and vote for validity, one voted high, 15 voted moderate, one voted low, and one voted for insufficient.

Wunmi Isijola: Thank you.

Lindsey Tighe: OK. Any discussion of the feasibility of the measure?

Yes. Do we have Jeff Burton or Linda Briggs any comments?

Linda Briggs: This is Linda. I don't have any problems with the feasibility. Again, my concern is related to the bare metal stents in patients period. You know, being included here because its recommendation is up to 12 months, not including 12 months.

Lindsey Tighe: OK.

Wunmi Isijola: OK.

Lindsey Tighe: Anyone also comments about the data's (birth) if it's generated during care and its data collection (chart) that it can be implemented? Just for purposes of us writing the report, is your silence to mean that you all agree that the data is generated during care, it's in electronic sources and the strategy can be implemented?

Wunmi Isijola: Is that a yes?

Male: Yes.

Female: Yes.

Male: Yes.

Wunmi Isijola: OK. Great. I just want to make sure we have people in the line. And with that being said, we will move forward with voting for feasibility starts now.

Lindsey Tighe: So for feasibility five voted high and 13 voted moderate.

Wunmi Isijola: OK. Thank you and then we'll move on to usability and use. Jeff or Linda do you have any comments?

Linda Briggs: No additional comments at this time.

Wunmi Isijola: OK.

Lindsey Tighe: OK. So voting – any committee members have any comments?

Wunmi Isijola: OK and with that being said we'll move forward with voting for usability and use. Voting starts now. OK.

Lindsey Tighe: So, for usability and use, zero voted high, 17 voted moderate, and one voted low.

Wunmi Isijola: OK.

Lindsey Tighe: And zero voted insufficient information.

Wunmi Isijola: Thank you.

Lindsey Tighe: OK.

Wunmi Isijola: So now we're going to vote on the overall suitability for endorsement, keeping in mind the discussion for the revised specs of the measure. Are there any comments before we vote?

OK. So with that being said we will vote now.

Lindsey Tighe: OK. So in conclusion, for overall suitability for endorsement 16 votes yes and one voted no.

Wunmi Isijola: Thank you. So this measure will be recommended for endorsement. Thank you Kyle for joining us. And with that being said we will move forward to measure 2452 PCI, Post-Procedural Optimal Medical therapy by ACA – ACC. Is there anyone on the call?

Lindsey Tighe: Do we have any developers from ACC to speak to – well they submitted over e-mail?

(Jansen): Yes. This is (Jansen), ACC staff.

Lindsey Tighe: Hi, (Jansen).

(Jansen): So what – remind me again, what do you want me speak to because this obviously can get quite technical, the coding discussion whether a specific issues you had, we can field questions. I don't know if we had to go through – are we going through the whole of this process or are we going through the whole importance reliability and validity testing and everything or?

Lindsey Tighe: No. This is Lindsey and (Jansen), so, the issue is really is that, there is a lot of confusion about the differences between measures 2452 and 0964 at the meeting. You already saying that they were identical except for the level of analysis and then in e-mail follow up with our staff. You highlighted some differences between the two measures so noting that they were harmonized.

So if you can just walk us through the differences between the two measures because we've like to give the committee the opportunity to understand why you believe there need to be two measures. And then essentially revote if they agree with your justification or ask you to harmonize the measures if they don't agree with your justification.

(Jansen): OK, good.

Lindsey Tighe: (Inaudible) combined and with that whole discussion that we had.

(Jansen): OK. To the harmonization piece, we'll price that with second. I think just the first piece we're on the same page what the both measures are. So 2452 is optimal care measure and then you're talking about that one in the 954, right? So those two measures look quite similar but they're slightly different. Those are the two measures they're referring to, right?

Wunmi Isijola: Correct.

(Jansen): OK. So that one – one of them obviously is the individual physician level and then which is 2452 and the 954 is the facility level. So the facility level measure had already been endorsed at NQF and that one, I think the issue came in to exclusion if I'm correct and the difference between the exclusions and exceptions.

So the measures are aligned but the issue being – and we tried to articulate it in the e-mail, but I'll try to keep it simple as I can. But, the issue being the facility level exclusion are, as you know pay up. So patients who expire, they died, left AMA medical advice. They also have patient that discharged to hospice, although they're exclusions for the, you know, the facility level and when we treat exclusions in the 954 measure exclusions there are – we treat those (actually) – I'm sorry, treat those as exceptions and those actually are contraindicated patients are actually considered a performance met.

The thought being that again this is 954, the thought being that when you're contraindicated the thought is – there should still be performance met and that was the facility level. Now at the individual physician level, again that's a different (in steward) ACC/AHA PCPI that one as you can see the note show that the exclusions are actually removed from the denominators. So therefore, the denominator population slightly shrunk.

Now having said that, those are really the only key differences I know in the group. At the meeting there are some concerns that's a very, very different measures. It really is the same meds. All those meds have been harmonized. They won't go through all the medications unless you want me too but all the medication are all the same, Aspirin P2Y12 statins. Those are all the same in denominator. Again, it's just how you calculate the exclusions and exceptions are slightly different.

Lindsey Tighe: Yes. Just to be clear (Jansen), the issue that was raised so that the measures are extremely similar and we wanted to understand what the justification for having two measures specified at different levels of analysis were versus having one measure that you are able to calculate at both levels of analysis.

(Jansen): Right. So, at the hospital level that one is obviously (is re-endorsed) and the individual physician level is not yet – well, a separate discussion still. So physicians obviously are always next in hospitals. That can lead to confusion. There are some operational issues in the individual physician level that are slightly different and then the hospital level A be the testing while it's a similar sources, you know, the (CAP) registry. Again, the testing provided was different and this is again more, I think, operational that the steward for the inpatient at the hospital level is ACC only, child patient ACC/AHA, PCPI.

So while it might seem kind of easy to merge, operation is a little tricky because they're both – while they appear very similar and I discussed all the similarities. The meds, all that is harmonized because those are three, based on the guidelines and everything. I won't go through all that. They are very, very, very similar and just operationally, they are carried across differently. But similar to other measures that we have in the portfolio, I know we talked about the rehab measure quite extensively so I'm bringing that up using it only as a corollary that you have an in and outpatient. So there are two different, again, there are different – in that case, the different populations, but yes they're somewhat similar.

So I know we're not going to talk about harmonization on that measure given the outpatient measure has failed. But again, it's more for the operations of putting this measure forward and currently the feasibility level measure is, as we know, the usability. The usability of the measures, again, are slightly different. So I can go through all of them if you want me to. But I think they are noted in the application the usability of these two measures.

Karen Johnson: So (Jansen) this is Karen Johnson, just a couple of question for you. In measure 2452, the patients who might be excluded for in that measure, the clinician level measure, would those same patients be excluded from the facility level measure or could you be excluding different patients because the specifications are different?

(Jansen): You could potentially be excluding different people. So 245, that was again – that one is the physician level manager and so everybody is in the same page, that's the physician level measure. And so, patients who expired, patients who

left AMA, patients discharged in the hospice and discharge, acute kind of care hospitals. In terms of the calculation for the individual physician level, that currently means that you're being removed from the denominator. It means you're shrinking the eligible population.

Judd Hollander: So this is Judd I have a question and I've heard what you said, but I guess if I try and take the approach that every measure is work. What you haven't done is give me a compelling reason that these can't be handled under one measure rather than two different measures. Like I don't see a reason why they can't be perfectly harmonized and put together (only) part of the two different levels. I do understand that there is, you know, slightly different stewardship for the measures but I don't think that's a compelling reason to have as well as our physicians report differently. Personally, I'd rather see people work out the stewardship politics for lack of a better word rather than have a separate measure because of it if it can all be done under one measure.

Wunmi Isijola: Any other comments from the committee?

Does the committee like to revote on this measure given the information presented today?

(Sam Churi): Excuse me. This is (Sam Churi) with the PCPI. Could I make a comment?

Wunmi Isijola: Sure.

(Sam Churi): Thank you.

I just wanted to sort of relate it to the stewardship issue. I know that probably across NQF staff portfolio of measure, this issue have come up I imagined a number of times where there is a measure at the facility level that is essentially measuring the same thing as the measure at the physician level. I know having developed a number of physician level measures over the years that we've certainly have seen measures that are very similar to ours at the facility level and often times those are both considered for endorsement and those are both considered different enough to get endorsed.

So I guess my question to NQF staff is how would you normally advise a committee when you have two similar measures that are addressing the sort of the same patient population and the same measure focus but they are different stewards. In the most instances that I'm aware of, they are different steward entirely and this is sort of the unique situation and that ACP is involved in both the facility and the physician level measure, but I guess – I think it would be helpful to consider this as you've considered other measures where the situation is essentially the same.

(Jansen): And the only thing I would add if I can, this is (Johnson) speaking again. I'm sorry to add in. I know we're past our time. We're looking at that as I know operation, I hear you Dr. Hollander if I heard correctly and others. But I think the challenge is, one thing I'd articulate is that the ACC/AHA, PCPI measure has a measure population that is slightly different than the other measures, the 954 and other measures. So if we are to harmonize this measure, this would actually impact various other measures. I'm not saying that's a good or bad thing. It just starts some other implications because we – if we harmonize it completely, the measure calculation have to be the exact same.

And so again there – while we've argued they're very similar, in other words there was a little bit slight differences, the medications and all that are the same. But I – thanks (Sam) for chiming in as well. I think – I don't know if NQF staff have any other input in that regard. But I don't think – I believe it had create gap before in past projects.

Judd Hollander: So (Jansen) can I ask you one question? It's Judd again and I guess fundamentally, I would want to be convinced that having two separate measures is going to improve quality of care. And so I would ask you to make the argument for the committee because, right, that's what it's all about, is how we're going to improve quality of care. And if we break it down and you could give us a compelling argument that having two separate measures is going to make it better for patients, then it would be easier to handle.

(Sam Churi): This is (Sam Churi) again. I think the question – I think that's an important question but I think I would maybe re-frame it a little bit to say this thing at the process is important to measure at the physician level. Do you think that

this can help differentiate quality across providers at the physician level? And if the answer is yes, then it would seem – I would argue that you shouldn't work the physician level measure related to this. But if the thinking of the committee is more that this is really more appropriate at facility level, then that seems like that would help make it the decision for you.

But I think the stewardship issue seems to be sort of getting in the way, but I see this is no different than other measures. For example, transferring at arrival for AMI where there's a facility level measure and the physician level measure. And I know that sort of popped out so that that maybe not the best example but I think what sort of seems to be the stewardship issue that's confusing the decision making here. But I guess again, I would say to answer the question of whether or not you believe a physician – this is a process of care that was different – that you'd be able to differentiate quality across physician provider.

Thomas Kottke: Thomas Kottke here. You know, it's possible that a physician who is operating in several hospitals, but only performs a small proportion of the total procedures in any hospital could be performing quite poorly but not be detected under the hospital measure.

Judd Hollander: So just so I answer since I think part of that question was directed to my comments. I'm a firm believer that measuring at the physician level is important. But I'm also a firm believer that as we put out more measures we should try and be as, you know, make it as efficient as possible for the people completing the data forms.

Lindsey Tighe: OK. This is Lindsey from NQF. So I'll just jump in on the process points here. So certainly we're at this time we were asking the committee to evaluate the measures independently, so 0964 at the facility level and 2452 at the clinician level. The conversation then as both measures are deemed to meet the criteria would be, do we need both of these measures? Are they harmonized to the greatest extent possible? And the committee can make a choice to – at that point, only use one of the measures for its endorsement, recommend to the developers to combine the measures, look for additional areas of harmonization of the measures but maintain them as separate.

We have seen this in the past and we had a measure that was created by the American College of Surgeons and another one by CDC. The developers work together to combine the measure into one at the behest of the committee. There is precedent through this. It's not something that we see particularly often but that is kind of within the purview of the Steering Committee's recommendation.

So in evaluating 2452, we do want to understand if it as a measure as standalone meets the NQF endorsement criteria. And if the committee deems that it does, then we want to consider it head to head with 954 to see if it makes sense to have two measures, combine them or further harmonize.

(Stephen): Lindsey, this is (Stephen). I think Judd is maybe asking a question about, you know, in our prior experience then, is that can anyone either developers, ACC, CMS, or NQF shed light on when measures like this happen, does having a separate sort of a hospital level as well as a physician level measure actually make care better? Or is one sufficient and we're talking about sort of measuring it several different levels or granularity that would, you know, create a lot of measure and lot of work and after to collect those measures, but not really make care better. You know as for me attribution standpoint to making care better. Was there one with the domino effect or this – do these two measures have equal important impact on making care better for our patients in populations.

Thomas James: This is Thomas James. Could I jump in just to talk about that particular concept that typically that payers and I'll speak for the commercial and Medicaid side, will use accountability measures that in parallel between the hospital side and the physician side? So that there it really it is an attempt to try to create synergies as far as the incentives go?

Lindsey Tighe: OK, I don't know that we can answer the question about whether one level of analysis is better than the other per se. But I do just want to reiterate that we want to look at 2452 in isolation to see whether or not it needs the evaluation criteria. As a reminder of the committee's final vote for endorsement on this was yes 11 no 11 so we we're split 50-50.

We wanted to use this opportunity to have further conversation to see if the committee wanted to change their vote based on the new information or additional time to marinate on this. The conversation is still sounding pretty split at this point. As, I mean the measure was voted consensus not reach, we're happy to put it out for comment at consensus not reach. And then revisit these issues after comment with input from NQF members in the public unless there's a motion from the committee to revote on 2452 at this point in time.

Hearing nothing I will leave it as it is and plan to revisit this after the comment period since we've got in a little more insight from a broader group of stakeholders.

Thank you everyone from the developer side who joined us for that discussion and we can talk offline if you have any questions.

Karen Johnson: OK, so this is Karen Johnson here. I'm standing in for (Reva) today she is cruising somewhere at the Atlantic. So kudos to her while we're trying to figure this C.V. measures out.

We have measure 0535 and 0536 on the agenda today mainly just to clear up on misunderstanding that came through in the in-person meeting. So just to recap those measures very quickly those were the 40-day all cause risk standardized mortality rate for PCPI and there were two different measures with (Samantha) sent to me. So the two different measures I'm looking at post PCI mortality.

In the in-person meeting the developer described the 30-day mortality measure as being, I don't know what the right word is, as being a little bit different than the in-person, I'm sorry in-hospital mortality measure by saying that the 30-day all cause mortality measure only looked at patient who did not die on the hospital. In fact that wasn't exactly a correct reference – representation of those measures.

The 30-day all cause looked at mortality from PCI up to 30 days. So that the two 30-day mortality measures includes those who died in the hospital as well

as those who died outside the hospital but within 30 days, so we just wanted to make sure that was clear to everyone first of all just because there was a little bit of misunderstanding in the in-person meeting.

So let me stop there and see if there's any question and then we'll go on to talk very briefly about relating and competing issues.

No question, OK. So basically what we have here with 0535 and 0536 as well as going from – not from memory, I looked it up, 0133 the in hospital mortality measure. What we have are three measures basically looking at post PCI mortality. So in NQF speak, that's what we (saw) competing measures.

So similar to what you discussed before. We just want to have a discussion about whether we really need to have three different mortality measures for the same condition.

So again the developers and I think are on the line so they could respond to this. But one question might be is there a reason, a good reason to have two different 30-day PCI mortality measures, one STEMI, one non-STEMI, given that they don't put this out for the in-hospital measure. And then also kind of related is there a reason to have in-hospital measure and a 30-day measure that includes the in-hospital death.

So may we could ask with developer to discrete briefly as to why they feel the need to have three different measure of what is conceptually the same thing. Again post PCI mortality and then we'll open up discussion.

(Jeffrey Curtis): So this is (Jeffrey Curtis) here representing ACC today on behalf on this measure. And again apologize for the confusion that there was about whether or not in-hospital mortalities were excluded from the 30-day measures. To answer your questions specifically. The first question is whether, you know, why you need to have the stratified 30-day mortality measures.

And, you know, there was a lot of discussion in the evolution of this particular measure set as to whether or not that was necessary. And then also whether or not those are the appropriate groups to stratify too.

In this case the consensus from the measure development team which included many members from the ACC and outside was that it was reasonable to stratify the measure and with these two populations because their expected outcomes were so different.

In keeping with that it also follows the protocols and methodology that had been adopted by Massachusetts and the (Mass Dec) experience in there public reporting of PCI outcomes that used similar registry data. So the reason why it evolved differently than the in-hospital measure has more to do with I think time and different groups that were developing these measures separately and at different points in time. But I do think that there is some justification or good justification as to why he would want to do that.

I think that the differences in the populations and they're expecting mortality only increases over time. So there's a perhaps a small justification for why you would do it for the 30-day versus the in-hospital mortality measures. But I think more than anything else it reflects differences in decision making as to key decisions and by two different groups developing the measures.

The second piece is why one might want in-hospital measure as well as the 30-day measure, I think it has more to do with what, you know, the differences between an optimal measure and what is a practical measure and recognizing the fact that they may have complementary roles.

And specifically but when I say that if you look at the – I think ACC/AHA guidelines for development of outcomes measures for public reporting it specifically states that a good measure should have a fixed time period for evaluation. And that measures that use in hospital evaluation or in-hospital timeframes alone may be prone to errors on the basis of differences and discharge and events that are post-discharge. So they do recommend a fixed timeframe.

So with the 30-day measures have it adhere to that and recommend that. The downside to that is that it's somewhat difficult to implement such a measure.

And particularly to implement it in a timely fashion given the difficulty of assessing outcomes of 30 days or any time post discharge.

So the in-hospital mortality measure is more of a – not a compromise but a different approach or prioritizes these things differently. Such that it does not meet the criteria of having a fixed period for evaluation, but it does have it isn't incredibly feasible and that hospitals can report their in-hospital mortality without any additional resources being dedicated.

So again I think in that sense we too much more timely and that the – this data can be aggregated much more rapidly than waiting around for an independent death index (dated) to become available.

So the measures are overlapping in some sense but we do feel the complimentary nature of them over, you know, overwhelm the downsides to them being overlapping. So I'll leave it at that and open for questions.

Wunmi Isijola: Are there any question or discussion?

Male: So being a presenter for 535, I would serve – agree what (Jeff) said because I think the feasibility in particularly usability of an inpatient versus 30-day measure would be different because, you know, (inaudible) said the factor that determine survival at in-hospital could be very, very different and faster to determine survival at 30 days. So they would be different action that a practice or physician could take.

And the other thing as (Jeff) had pointed out that to separate STEMI shock versus non-STEMI shock, I think is also important because if you (comp) them all together you're going to get an average number whereas we know for 535 which is with (no shock) and without STEMI, those mortality rates are actually quite low compared to patients with STEMI and with shock.

Wunmi Isijola: And other discussion? George, do you have anything to add or?

George Philippides: No, I'm fine.

Karen Johnson: OK, thank you

Wunmi Isijola: OK, so what were going to do now is open it up for member and public commenting. (Amy), could you make sure that all lines are open.

Operator: Yes, ma'am, all lines are opened.

Lindsey Tighe: OK. Anyone has any comments? Please feel free to speak up.

Wunmi Isijola: OK. So thank you again all for participating in this call. So next step, we will be incorporating a lot of the discussion today as well as from the two-day meeting into our draft report which will go up for public commenting on May 27th. We will be in touch if in fact we do receive comments from two of the developers as well as to committee for response and if you do have any questions or concerns, please do let us know.

OK, and with that being said, we will adjourn early. Thank you again for participating.

Female: Thank you.

Male: Thank you.

Female: Thank you.

Female: Thank you.

Operator: This concludes today's call. Thank you and you may now disconnect.

END