NATIONAL QUALITY FORUM

Moderator: Cardiovascular Steering Committee
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2:00 p.m. ET

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

Wunmi Isijola: Thank you, (Brandy). Hello everyone and good afternoon. I hope everyone enjoys their many break. Welcome to the Cardiovascular Post-Comment Call.

Just before we get started, I wanted to introduce our team here. My name is Wunmi Isijola, the Project Manager. We have Lindsey Tighe, Vy Luong and Reva Winkler. We also want to get a sense of who's on the call. So, I will be doing a brief roll call of the committee members.

Mary George, are you on the line?

Mary George: Yes, I am.

Wunmi Isijola: Great, thank you. Thomas Kottke?

Thomas Kottke: I am.

Wunmi Isijola: Thank you, Tom. Sana Al-Khatib?

Sana Al-Khatib: Yes, I'm here. Thank you.

Wunmi Isijola: Thank you. Carol Allred?

Carol Allred: I'm here.

Wunmi Isijola: Thank you. Linda Briggs?

Linda Briggs: Here.

Wunmi Isijola: Thank you. Jeffrey Burton? OK. Leslie Cho? I know Joseph Cleveland just sent a note. Michael Crouch?

OK. Elizabeth DeLong? Ted Gibbons? Ellen Hillegass?

Ellen Hillegass: Present.

Wunmi Isijola: Thank you. Did I hear Ted? OK. So, Judd Hollander?

Judd Hollander: Yes.

Wunmi Isijola: Thank you. Thomas James?

Thomas James: I'm here.

Wunmi Isijola: Great, thank you. Joel Marrs?

Joel Marrs: Yes, I'm here.

Wunmi Isijola: Thank you, Joel. Kristi Mitchell?

Kristi Mitchell: I'm here.

Wunmi Isijola: Thank you. George Philippides? OK. Nicholas Ruggiero? Jason Spangler?

Jason Spangler: Present.

Wunmi Isijola: Thank you, Jason. Christine Stearns? Henry Ting? OK. Mark Valentine? Mladen Vidovich? OK.

Is there anyone I did not call who's recently joined?

Carl Tommaso: It's Carl Tommaso. I'm one of the authors of one of the performance measures for PCI.

Wunmi Isijola: Thank you, Carl. And are there any other developers on the call?

Male: This is (Inaudible) calling. I'm also from the American College of Cardiology for the heart failure measures.

Wunmi Isijola: OK.

(Reynold Thomas): This is (Reynold Thomas). I'm also part of the ACC measures for cardiac rehab referral.

Wunmi Isijola: OK.

Karen Lui: Karen Lui, also AACVPR on the cardiac rehab referral measure.

Wunmi Isijola: OK.

Marjorie King: Marjorie King, also AACVPR and ACC cardiac rehab measure.

Wunmi Isijola: OK. Thank you. Is there anyone else?

(Crosstalk)

(Dale Bratzler): (Dale Bratzler).

Female: This is (Inaudible).

Wunmi Isijola: OK. And then I heard, (Dale)?

(Dale Bratzler): Yes, I'm here for the CMS measures on the transfer patients.

Wunmi Isijola: Great. Thank you. Is there anyone else?

Lara Slattery: Hi. This is Lara Slattery for ACC.

Wunmi Isijola: Thank you, Lara.

(Toren Matkey): (Toren Matkey) for (Rand).

Kristina McCoy: Kristina McCoy with ACC is also on the line.

Wunmi Isijola: Thank you.

Female: (Inaudible) here, ACC/AHA.

Wunmi Isijola: Thank you.

(Trisha Connelly): Hi. (Trisha Connelly) with the ARG measure for ACC.

Wunmi Isijola: OK. Thank you.

Jensen Chiu: Wunmi, it's Jensen Chiu, ACC.

Wunmi Isijola: Thank you, Jensen. Anyone else?

Kyle Campbell: This is Kyle Campbell from FMQAI for CMS NQF 2379.

Wunmi Isijola: Thank you, Kyle.

Kyle Campbell: Thank you.

Wunmi Isijola: OK. So, if we haven't identified anyone else, we'll go ahead and get started with the call. So, as you know, this is the post-comment call. We did have a 30-day commenting period where we've pretty much sent out all of the measures for commenting, specifically, the deliberations made by the committee. And what we have done was we've compiled all of the comments based on similar themes and we would like to review them with the committee to see if they had in fact any additional comments as it relates to the comments received and the developer responses.

So, what we'll do is we will review each of the (schematic) comments and propose the committee for discussion and to see if in fact they have any revisions to the responses provided as well as reconsideration of any of the measures for potential rebuilding.

Reva, did you want to chime in and say anything?

Reva Winkler: No, thank you, Wunmi. And what we've tried to do is lay out a kind of the comments in an actionable way for the committee to review. And so, if

you've got the memo, that will be your best resource because essentially it lays out discussions we'd like you to consider.

Essentially, the comment period is feedback from the NQF members as well as the public at large, giving you some sense of how your main audience is reacting to the recommendations you've made. We ask that you really consider the comments carefully and consider how they might change your recommendations.

If not changing your recommendations, it can add to the discussion and (inaudible).

Wunmi Isijola: (Brandy), could you mute that line, please?

Reva Winkler: It can help us add more information origins in the discussion of your deliberations. And so, that's what we need to get through today in preparation of making a just – making revisions to the draft report before it goes out for NQF member voting.

Wunmi Isijola: OK. So, what we'll get started is we'll go the first team which were the measures for which consensus was not reached. As you may recall from the two-day meeting, measure 2452 and measure 0964, there was discussions surrounding harmonization and the possibility of combining the two measures.

We actually had in fact conducted a phone call with those developers for their take on that recommendation by the committee. And we have supply that to the committee members. I don't know if everyone had a chance to look at that memo, and we wanted to see after reviewing that letter from the developer and the comments received during that time period if the committee would like to go or have further discussion on those two measures and questions.

And I would also post it to the discussants who actually led those two, so I see Michael Crouch and I believe Judd Hollander for 2452. And Sana and Michael Crouch, if you had any discussions surrounding those two measures and questions.

And maybe it'll be helpful for the developers to chime in to kind of discuss kind of their rationale.

Sana Al-Khatib: Wunmi, if I can actually chime in. This is Sana Al-Khatib.

Wunmi Isijola: OK.

Sana Al-Khatib: I actually was not the primary reviewer for 2452 but I was the primary reviewer for 0964. And I think the main concerns that we had during the meeting about having those measures in place were number one that we didn't feel that they were very well-harmonized and then the other question was whether there was any value of having two measures, one at the facility level and one at the provider level.

And, you know, I read very carefully the response that was drafted by the developers. They think they actually made the case for why this measure should be in place the – so at least from my perspective, speaking for myself, I don't have the same concerns that I had about measure 2452 when we had the meeting back in April.

Judd Hollander: So, this is Judd. I think that I have a slightly different response to this. And my concern has more to do with harmonization rather than duplicate measures. And I think all the items in their response were things that we discussed around the table. And so, I don't see, you know, other than the sponsors nor the measure developer is restating the opinions that we already discussed that there's anything that should change anybody's mind.

I think that I like to look at this first from the work point of view and it's less important to me who owns the measure development which really seems to be the issue here. And I think it would be better if the measure developers got on the same table rather than the people filling out all the forms and paperwork and then turning it electronically, do it in a duplicative manner just so that there could be separate ownership.

I am fine with both measures existing. That's not my issue. My issue is purely one of harmonization and what prevents them from being really well-harmonized is the measure developers not being able to coordinate. And

frankly, I would rather have more pressure on them to coordinate than the people who are completing the measures. So – and I think those the things we all discussed around the table. I don't see another argument that should change the initial opinions.

Wunmi Isijola: Would the developer like to respond to that?

Carl Tommaso: Well, it's Dr. Tommaso, I'm one of the developers here. Knowing that both of these measures were going to be presented, our point is that since the interventionalist is responsible for the dual antiplatelet therapy, make them responsible for, or she, responsible for all the optimum medical therapy was a logical progression of step one. So, we felt that although these patients may go through hospitalist, intensivist, internist, that it had to start somewhere and we wanted to start with the interventional cardiologist.

Wunmi Isijola: Are there any other comment from the committee?

(Sam Kearney): This is (Sam Kearney) …

Thomas Kottke: Tom Kottke here. I would just say anecdotally in our institutions that if the interventionalist writes the orders for medications, they just don't get changed by anybody else during the remainder of the hospital period.

So, that means I agree with the last point being made.

Carl Tommaso: I'm not sure that last point responded to the issues that we were concerned around the table. So, I understand that that was something we discussed but I don't see how that impacts harmonization.

Thomas James: This is Tom James. As we've – as from my health plan point of view, we're concerned about both the – where the accountability is, and it really is in anyone's system, a shared accountability. So, as long as we have a measure which does demonstrate that sharing, whether it's two separate measures or whether it's one consistent measure and we would be fine with that.

(Sam Kearney): This is (Sam Kearney) with the AMA-PCPI. This is a follow-up question if I may. I think it was Dr. Hollander, you were referring to the fact that you

didn't believe the measures were harmonized and you felt that there would be duplicative efforts. And I just wondered if you could expand upon that of that. I know there was a table provided that compares all of the different aspects of the measures and we do believe that they are harmonized. So, I think in terms of implementation, it really would be the same set of information that would be entered. It would just be – the analysis would be at different levels of measurement. So, I just wondered if you could expand upon that harmonization to a bit more so we could respond to it.

Judd Hollander: So, is that information entered in one database or two databases?

(Sam Kearney): I believe it's one, I would ask maybe my colleague with ACC who are more familiar with the registry implementation to comment but I believe it's just entered once.

Female: Yes, my understanding is that it is just using the one database which is the CathPCI. I didn't see any reason to believe that there will be, you know, other, you know, different registries or different databases used for the two different measures.

Judd Hollander: OK. You know and I understand. I'm trying to remember back to the conversation that took place a couple of months ago around the table. So …

Female: And so, the main reason why those two were not harmonized is that it's I think it's what's mostly the exclusions. If I remember all the details, there were issues with the exclusions and the exceptions. And so the table that the lady who was on the line, I didn't get her name that she's referring to is the table that what's been to what – to review before this call that really compares how and shows how just the two measures are now much better harmonized in terms of the exclusions and the exceptions than they were before when we discussed them, you know, at that one meeting. So, that's why I'm also a bit confused by your comment that lack of harmonization, maybe I missed something.

Judd Hollander: OK. Maybe I missed the table. I don't recall seeing the table and I didn't look over the documents but I wasn't able to access them till today because I'm in a new job and just got my computer up and running this morning. So, I may

have missed that but I will take your word for that and then I think I probably have not further objections.

Male: Yes, I think after the harmonization in that table, the only real difference was is to where the responsibility was, either at the time of discharge or by the interventional cardiologist.

Wunmi Isijola: Is there any other comments?

Reva Winkler: Wunmi, this is Reva. I just want to point out that in addition to the harmonization to measure issue, there were two comments submitted from NQF members around this measure as one was about harmonization, the drug inclusion. But one was actually addressing the issue of rather than having measures that simply look for discharge prescriptions to look at measures that address adherence after the procedure. And so, it would be helpful for the committee to make some comments so that we can craft an appropriate response to the comment.

Carl Tommaso: This is Dr. Tommaso again, one of the authors. We had talked about how to measure adherence. And we didn't think that there's any practical way to be able to do that. We think that in the future, monitoring adherence is going to be extremely important. But – and right now, we don't think there's a mechanism to do that.

Female: So this is …

Female: So, this is – I actually completed the agreement. And you may recall that we discussed this very issue during our in-person meeting and we talked about how adherence would be much more important to try to catch her. But then we said that it's very hard to assess adherence. I mean the person who provided that comment alluded to the fact that we may, you know, administrative claims data and Medicare Part D, what have you to see if the prescription was filled. But even – I mean and that would be actually pretty – I wouldn't think that this would be easy to do. But even if it was easy to do, if the patient filled the prescription, this doesn't mean that they're taking the medication.

Mary George: This is Mary George and I agree that the adherence is much more difficult to try to measure. But that would also be creating a completely different measure than what we were presented by the developers. And I think we have …

Thomas Kottke: Yes. Tom Kottke …

Mary George: … concerns, completely changing a measure that drastically.

Thomas Kottke: Yes, Tom Kottke here. I think somebody would have to demonstrate use and usability. The measuring adherence is well beyond the technical capabilities of any individual provider and is probably beyond the capabilities of hospitals. And it challenges the capabilities of health plans because there is by definition is persistent, is number of doses taken per unit of time it fills. And so, adherence is far more complicated and issues in a single word seems to imply.

Reva Winkler: OK. This is Reva again. So, if there are no further discussion on this measure because the prior voted committee was no consensus reached, we're going to ask you to read those now that you've had this feedback and further discussion so that we can see where the committee is prior to taking it to the NQF membership for voting. So, we're making – tell you how they're going to collect, how we're going to collect the votes for that.

Wunmi Isijola: Hi. Thank you, Reva. And you should have received a SurveyMonkey link prior to the call. So, we would like you to make your votes accordingly in that manner and then we will capture that to see if we need to move it on into the member voting for additional consideration.

Thomas Kottke: So, Tom here. I have a procedural question both best measure 2452 and 0643 show up on there. Do you want us to just hold our vote until, our submission until we vote on the other two or …

Wunmi Isijola: That's correct. That just makes some sense.

Female: Yes, we'll have a discussion on 0643 next and then you can vote on both measures.

Wunmi Isijola: OK. If there's no other questions or comments, we'll move on to measure 0643.

Female: (Inaudible) during the in-person meeting (inaudible) with the wording of the specifications for measure 0643 and that wording implied that patients with chronic stable angina would be to be referred to cardiac rehab annually. At the post-meeting call, the developer provided some updated language that addresses the committee's concerns. And then during that post-comment call, there was also some concern very effective and that there is already a companion measure that requires referral at discharge for patients but having to follow on measure that requires an additional referral with the outpatient provider, maybe somewhat duplicative.

So, that was the issue raised. We also received some comments, some in support of the measure and then others just raising some other concerns laid for you in the memo. So, I will pause there and open it for completion. I particularly (inaudible) have anything to add.

Thomas Kottke: Yes, Tom Kottke here. I was the primary discussant and brought up the issue of the chronic stable angina of the proposal or these sponsors of – to solve that issue with the wording. One of the major objections was that a single question would be burdensome to cardiologists who were doing intake of patients who they had an outpatient procedure.

As context, I'd like to point out that we're asking in the heart failure measure for each patient who has a diagnose of heart failure to answer for example the Minnesota Living with heart failure questionnaire which is 21 questions. We're asking them to fill that out at every visit. And so, I think the burdensomeness of this measure is minimal if not existent.

The other suggestion has been that it should be participation. The measure should be participation rather than referral. I wish Leslie Cho were on the line because she …

Leslie Cho: I'm on the line.

Thomas Kottke: Oh you're on. Good. Because you had mentioned that you had made referral a standing order and nothing had changed in terms of participation. And unless if we say that it's participation, we just don't know where the breakdown is in the system. And so, I think that we have to endorse measure as it stands.

It's important, there's a direct length between cardiac rehabilitation and outcomes. A single – I don't believe a single question is burdensome, and I think it's important to assess referrals.

Female: You know, maybe someone can tell me how did the measure developers rephrase the chronic stable angina?

Wunmi Isijola: That's on page four of the memo.

Female: Page four of the memo.

Wunmi Isijola: The wording.

Female: I'm looking at the memo.

Wunmi Isijola: I can read it to you if you'd like.

Female: Hold on, hold on, let me see.

Wunmi Isijola: Second paragraph.

Thomas Kottke: Yes, basically, there's a new or worsening angina that does not meet the criteria for unstable angina.

Female: You know, I think that most of us would agree that it's not that it's burdensome but my biggest problem was everybody agrees cardiac rehab is like what I wanted from the developer was if a patient gets the referral from the inpatient and somehow, you know, they get a referral, they go to cardiac rehab but it's not documented in the outpatient clinic, then the thing is – then

the patient or – I mean the physician or the institution (is dinged), not having this quality.

So, I wanted the developers to try to figure out a way for the institution and the physicians not to be (dinged). But I looked through the comments. I didn't really see that, maybe I didn't – maybe I'm just not reading correct places.

(Randy Thomas): This is (Randy Thomas): No we – I think maybe just in this agreement on, you know, constitutes the importance of the measure (preps). If you look at for example another measure like the use of beta block or asthma therapy following MI, I think we probably all agree that's a reasonable expectation that if we see a patient in the outpatient setting who somebody else started on an indicated treatment like beta blocker or asthma therapy.

There's no reason for us to reassess whether or not they're on therapy. And likewise, if someone has been previously referred to cardiac (rate) from an inpatient setting, the outpatient provider can reasonably be expected to reassess to make sure they have received that therapy to reinforce its importance. I don't see an overly burdensome requirement and keeping that in. That may give me a different set of opinion but I think it's …

(Crosstalk)

Female: But NQF does not have two separate endorsements for beta blocker use support – like for instance, if we take your corollary, then we definitely had in the NQF, you know, all these like standard of care measures after a STEMI. We don't have the same measures for outpatient. Bringing patients – bringing physicians or whatnot or holding patients accountable for the same patient and the inpatient as well as in the outpatient setting, we do not have that.

Thomas Kottke: It's Tom Kottke here. I may be stand corrected but I think there are measures about persistence of therapies, aren't there or not only?

Reva Winkler: This is Reva. Yes, we actually – and you will see them in the coming years as we do next generations of cardiovascular measures. We do have measures

from that are both in the inpatient typically. Medications are at discharge versus medications for patients being seen in the outpatient world.

Specifically around AMI and beta blockers, there is an outpatient measure on, you know, patients taking beta blockers for six months after an AMI. So, there really is both inpatient and outpatient on most of the medications.

Female: Is it coming or is it already here?

Reva Winkler: Yes.

Female: Is it already present or is it coming?

Reva Winkler: It doesn't matter. It's what it – it's measured at the time the patient is seen as an outpatient.

Male: Reva, what she's asking is, are these existing measures or are they planned measures?

Reva Winkler: No, no, they're existing. It's been endorsed for a very long time.

(Randy Thomas): Yes, this is (Randy Thomas). The other thing I just point out is that this measure is designed to also capture those patients who do not receive care in the inpatient setting. So, they're in outpatient events so to speak then quality them for cardiac rehabilitation. So, it's really doing two things. It's making sure that there's a double check on whether or not the patient has been referred from an inpatient setting, I guess you can say. But more importantly, it's capturing those who have an outpatient event and need to referred.

Female: Is the measure still relying on the ACC outpatient database? Or is the measure – how are we assessing if someone gets referred for outpatient rehab? Is it based on the – what is basis of this?

(Randy Thomas): It's on the – that was based on the report as a clinician and the patient.

Female: No, I know, but, you know how …

(Randy Thomas): Registries can be used because that's just one way that can be used. It's not a requirement with the ACC registry and be used.

Female: So, it will be like basically a chart review?

(Randy Thomas): It can be a registry, whatever the system is using. You know, we're in the process of working through the E specification of the measures. But right now, it's specified as either chart review or electronic assessment or whatever they have in use.

Female: So, for a – let's say a patient goes to a cardiologist office, you know, a private practice office after they've had their procedure at a hospital and they were electro procedures so they went home within 24 hours. And so, at the outpatient clinician's office, they would have to do a chart review to see whether a patient was referred for rehab or not.

(Randy Thomas): That would be – I guess that's the only way they can do and they have another way set up. That's really one way they can do it.

Male: And they could certainly ask the patient (inaudible) and put something up that's just patient was referred or patient was not referred.

Female: But it's still a chart. They don't have registry. It's still a chart review.

Thomas James: This is Tom James, if I could get in a different direction. Problem that we've got is that this is a process measure and it's not an outcomes measure. The real outcomes is, is the patient in cardiac rehab, not that someone checked the box, the order that a referral is being made. And so, we've discussed (inaudible). I don't particularly care for this measure.

(Randy Thomas): Yes, so this is (Randy Thomas). Thanks for the comment. We have discussed this on previous calls in the two other previous times we've been as to have endorsement on the measure. And as we've mentioned before, the writing group decided to focus on referral which is the initial step to getting patients into cardiac rehabilitation.

Actually, the ultimate outcome would be mortality and recurrent events. We also agree that it's important to work toward having participation included. I've worked with the folks in Canada who've been putting their performance measures together and they have included participation in their measures. But our initial step when we started this process in 2005, 2006 was to start with the initial step that gets people into cardiac rehabilitation which was a big – and still is a big source of the gap and cure.

So, that's the easiest most feasible step that we thought to take initially with the plan that we would also be including in a later version, the participation and ultimate heart outcomes for patients as well.

Thomas James: I understand.

Elizabeth DeLong: This is Liz DeLong. I guess I'm a little concerned about approving measures of first step – I mean, what does it actually get us if the goal is not to finalize that as a measure but to move on?

(Randy Thomas): Yes, so that's a good question, too. So, if you look at some materials that we've provided, there's a recent study looking at the ACC registry, looking to see if the measures that were developed in these measures inpatient and outpatient. If they appear to have had any impact on referral over the past seven years that they've been available and this is – we can provide you with a reference again if you need that. And the document has been significantly increased from the, you know, 30 percent to 40 percent range up into the 70 percent range of referral to rehab.

Participation rates are different story. We're in the process of putting together a paper on that, but I think if your question is, you know, does the initial step, these measures have an impact, the answer is based on this one study would be – it looks like a significant yes, whether or not it's leading to increase in participation rates is the second question that needs to be answered. And like I said, the data are being evaluated right now. But certainly, they're not going to be – the participation rates will not increase unless the referral rates increase. And (inaudible) to show the measures have probably led to significant increase in referral rates.

Sana Al-Khatib: So, I have a couple of questions. This is Sana Al-Khatib. So, and the way I view this measure and please correct me if I'm wrong is so we have the measure in terms of the inpatient setting. And my thinking of this measure now based on the revisions that were made to it is that maybe this is an added layer of surveillance if you will that if things didn't happen in the inpatient setting, now you're catching the downstream and offer because what we're going to except for that one definition of, you know, new angina or worsening angina that does not meet the definition of unstable angina that by the way, I still don't understand what that means.

But it also talks about these people who had an MI before, who had surgery. Of course, all those people were, you know, in an inpatient setting was that that inpatient setting measure would have applied. So, the way I'm viewing this now is you're trying to capture these patients in case they were not referred for rehab, you know, in the inpatient setting.

Am I interpreting these changes the right way?

(Randy Thomas): I mean that's certainly one purpose but I think the major purpose for me to pick up individuals who had an outpatient event primarily. In the primary defect on the inpatient side, you know, as we correct the inpatient referral process in all the centers around the country, you know, it's our hope to referral rates will, you know, get up into the more optimal range all around. And that's where the defect needs to be fixed or the inpatient referral. But there are an increasing number of outpatients who are possible for cardiac rehabilitation, the stable angina will be one, PCR would be another. We have increasing numbers of groups that are in that eligible range with the number of, you know, procedures are being done today. It seems like with the valvular disease and another processes.

We have heart failure which is now been approved, not part of this referral measure but will be in the future. That certainly an outpatient diagnosis in many cases as well. So, it's really – it does help to capture (inaudible) but I think primarily, it's helping to get those of an outpatient event.

Marjorie King: This is Marjorie King, another one of the measure developers. I actually agree with the person who made the comment about this measure being designed to capture those patients who either weren't referred or who were referred but just weren't ready from a behavioral perspective.

Participation in cardiac rehab has really involved shared accountability among all the providers involved with the patient as well as the patient and the patient's family to get them there into – for them to understand that it's important. So, yes, this measure does also have an important role for the provider to just ask a simple question, are you going to cardiac rehab? And if they say, no, I'm not, I did think it was a good idea than to just reinforce, it's a good idea, or if, no, somebody told me, here's the referral, here's the prescription. It really – it carries multiple – does multiple things, this (inaudible) referral measure, this outpatient referral measure.

Wunmi Isijola: Are there any other comments? OK. So, it's not based on the discussion and the revision are presented by the developers. We do ask you to reconsider your recommendations for measure 0643 and that's also within the SurveyMonkey link.

So, if there aren't any other comments, we will move forward to our next theme, which was the recommendations for improved measures or alternative approaches. Based on the comment submitted by the public and membership, there were requests for revisions with some of the measures with regard to meaningful information. I know we just spoke to 0642 as well as 0643. Are there any comments regarding what was presented? OK.

Reva Winkler: This is Reva. I just wanted to mention that this is the kind of comment we get fairly regularly often from the consumer and purchaser world. But for those that are – but certainly from those who are looking to see measure development or measures being used continue to evolve and push forward to provide more meaningful information.

And one of the questions that I would want to – I'd like the committee to think about is as you look and evaluate measures, what is the appropriate strategy to encourage, you know, better measures more, meaningful measures that are

going to be more useful for a wide variety of stakeholders as you evaluate those in front of you but maybe wish it was something different or not.

So, I was going to ask Tom James to maybe comment since, you know, I have put in a fair number of these comments.

Thomas James: Which – hey, do you want me to comment on right first?

Reva Winkler: Well (inaudible), your choice.

Thomas James: To me, it seems that it, you know, since I'm a practicing physician part of the time and I'm a health plan administrator part of the time that the various reasons for having measures makes them important to one group but not to another.

So, the one that I just made a comment on about the referral for rehab. As a practicing physician, I want to make sure that I'm doing that when I'm working with the cardiologist in the hospital. But as a health plan person, I'm looking at it from a population point of view and I want know that there's an outcome that is more likely to be associated with improved outcomes and that's actually getting into rehab. So, for that reason, I think we have to have some way of grading these measures in a way that says why they're important to which groups.

I co-chair of the AQA's Public reporting Workgroup (inaudible). So, we got the ACC involved with that. And we're going through that process saying, not all measures are equally important to everybody.

So, that's really kind of context for all of these discussions that you got there. It's really saying – we should be assigning a level of importance to which group, not just to the accountable. Does that help?

Reva Winkler: Thanks, Tom. Any thoughts from any other committee members? I think unlike it – you've served on other committees in the past. The fact that you're now a standing committee with responsibility for the entire portfolio brings this type of a question to you, to think about how do we put together a portfolio measures that is the most useful and meaningful to a wide variety of

stakeholders. And as you are evaluating and making recommendation to measures, that will be an important aspect to perhaps has not been something we'd ask committees to do in the past.

Sana Al-Khatib: This is Sana Al-Khatib. Just a couple of comments on this and I completely agree with, you know, if not all of these comments that were made that if we can actually get this information, it's feasible, if it's doable, then I think that's what we should aim for.

But for example, as we talked about in relation to measure 0964, 2452, talking about, you know, adherence. We discussed this and we said, "Well, how do you measure that? How do you do it?" So, although some of these ideas are really good ideas. And, you know, in my dreams, I wish we could do this. We have to be faced with the reality of what's feasible and what's doable and what's not. So, I think what I would add is I encourage us to be open-minded and think about these in a ways to improve the measures that we have or we also have to take into account what's doable and what's not.

Leslie Cho: It's Leslie Cho. I think also, you know, we've been thinking a lot about – I've been thinking a lot about rehab but I think that some of these quality measures are – should be actually part of like an insurance plan.

So, for your – So, besides just saying, we have to have patients go to cardiac rehab which I, you know, we all agree. If patients don't go to cardiac rehab or if they don't get referred, there should be some teeth behind it. And the only people who can really put their teeth behind it is people with money like insurance companies. And I think that, you know, for us to say every patient should get a cardiac rehab, referral as an outpatient which, you know, is a good idea, they qualify or whatnot, but to then have, you know, like electronic medical review and all these sort of things that really don't really get patients to cardiac rehab or actually don't reward physicians for getting patients to cardiac rehab or whatnot.

I mean I think that sometimes, we are – we're getting like the measure of fatigue with all these like one measure after another measure after another measure, there's some amount of fatigue to that build up.

Elizabeth DeLong: This is Liz DeLong again. I absolutely agree. I think that we need to make sure our measures are not only collectable but they're meaningful. And as you said, the number of referrals went up. That means the box got checked a lot. But without real substantive evidence that it made a – there was an impact, it's not clear to me that it's worth adding another measure.

Wunmi Isijola: Are there any other comments or discussions? OK. And with that, for the question that we're posing to the committee, do you encourage NQF while you're encouraging more meaningful measures? So, if we want to be able to compose (our response) to the comments presented.

Linda Briggs: This is Linda Briggs. I don't know that I would phrase it as more meaningful measures as much as I would say that we need to make a move whenever possible to move away from process and towards an outcome measure. And, you know, it may be an intermediary outcome like going to cardiac rehab where the ultimate outcome is mortality or survival. But at least when you like we get to the point where we're actually measuring the number of people that actually go to cardiac rehab while there are a lot of barriers to getting that number right now, we need to figure out as a nation how we get to some of that information.

Mary George: This is Mary and I think it really depends on what the gaps are and care as to whether you're focusing on something that's a bit more of a process measure that moves you closely to an outcome. Its adherence to the process measure is poor, you know, it really depends on where you are and driving care. And sometimes, you have to start more proximal with process measures.

Sana Al-Khatib: So, can I ask a question? This is Sana Al-Khatib again. So, part of the process of the NQF, at least my understanding of it is that once these measures go into practice that, you know, hopefully that developers are expected to measure the impact of these performance measures and so when these measures are up for renewal, hopefully that is or would be a criteria in by which these measures could be judged. Is this actually part of the review process or am I imagining things?

Reva Winkler: Sana, it's Reva. I mean one of the things as you evaluated many of the measures that are already endorsed for their maintenance review, one of the things we do focus in on are current results, opportunity for improvement, how the measures are being used under usability and use. So, those are very much criteria and we've certainly hear from other, you know, steering committee members that, you know, for maintenance measures, those become some of the most significant criteria to look at the measure.

Sana Al-Khatib: Thank you.

Linda Briggs: This is Linda Briggs. Along those lines, it's my understanding that 6043, the outpatient cardiac rehab indicator, that actually was endorsed in 2010. So, this is an existing indicator and my understanding is that it's – well, it's not publicly reported. It's used in TQRS and so, looking at the information in terms of what's coming out of TQRS and how, you know, feasible it was to collect that data there and what the effects were are important.

Wunmi Isijola: Thank you, Linda. OK. I think we can crop some appropriate responses and add some wordage to some of the draft report to reflect this discussion. So, if there's nothing else, we can move on to the next one.

The next theme is the (inaudible) (burdens) to participate in multiple registries. And although it was only came from one commenter, particularly in the area of cardiovascular where we saw a lot of measures from multiple or from different registries, it's probably important for the committee to think about and discuss the impact on providers and people being measured when we have measures coming from multiple registries that they have to participate in.

Thoughts from anybody?

Linda Briggs: This is Linda again. We did talk about the cost of registries for a lengthy time period during our face-to-face meeting and we talked about the CathPCI Registry being used by over 90 percent of the cath labs across the country was what was reported to us.

Now, there was one comment that we received in the table that had to do with one hospital thing that, you know, the one indicator related I believe it was just smoking cessation in the Action Registry wouldn't be captured in the PCI Registry and they couldn't afford the Action Registry which was just again evidence that there – that this could be a problem when we require, we're asking people to have multiple registries.

Female: I think it's a really valid point. It's (inaudible). I think it's a really valid point that the hospitals bring up about the cost of registry, even though PCI, the NCDR PCI Registry is widely accepted, the outpatient ACC database is not.

And I think that no, we should be mindful with that. And it's a very, very good point people bring up. And obviously, (current) review is also very expensive too, but the registry issue is I think very valid.

Carl Tommaso: This is Carl Tommaso again. In our measure, we said that a lab should belong to a registry, whether it was NCDR, a state registry where the states have mandated submission of data or a regional registry like the New England Registry.

We didn't say that people had a respond, had to belong to multiple registries. As long as they were responding to one – who's submitting to one registry, it fulfilled our criteria.

Reva Winkler: This is Reva.

Female: Yes, go ahead, Reva.

Reva Winkler: Go ahead.

Female: I just wanted to add that this is assuming that the data that are required, the data elements that are required for a particular measure are actually present in this other registry.

And so, I think to the extent that we can encourage developers to be thinking about that when they're developing and especially like ACC for example where they have so many different registries can – even providing some, you

know, thoughts or suggestions or recommendations as to which of their registries could be actually used for a particular measure I think would be helpful.

Reva Winkler: Yes, this is Reva. What I was going to say was, you know, the CathPCI Registry, my understanding is it's just for patients who've undergone PCI. The Action Registry is more for patients who've had heart failure. So, as we have multiple registries for different types of patients, then I think it's really the issue rather than alternatives to a registry safe for just for PCI patients.

Linda Briggs: This is Linda again. The issue came up under 2377 in the comments related to defect-free acute MI care. And the comment was from Overlake Hospital and they were talking about that the CathPCI Registry doesn't have the smoking cessation piece that they would need to basically able to respond to all the pieces of that to particular indicator and I guess that they looked at the Action Registry and that it would.

And one of the issues is that CathPCI does not necessarily encompass all of the MI patients. So, their recommendation to adding smoking cessation to that particular registry would not solve the issue of needing to figure out how you're going to collect that data, whether it's – and the recommended registry towards that particular indicator apparently was the Action Registry, you know, how you would collect that data otherwise.

Female: So, the action registry actually is not a heart failure registry. It is a registry of ACS patients, so you would expect to have some overlap between Action and CathPCI, but I could also see a lot of, you know, no overlap between the two registries.

Thomas Kottke: Tom Kottke here. You know, I think we're on a bit of a slippery slope here or maybe of course before the cart to say that the presence of data in registries drives the measures I think that – I mean what other driving measures is good health care – we're spending 18 percent of gross national product on health care and a third of that is probably waste initiatives.

So, I think that people who deliver health care do have some obligation to believe that providing data and justification is part of doing business.

Linda Briggs: This is Linda again. I would agree with that. However, part of the costs are also, all of the data reporting and monitoring that we do. So, if you don't have an easy way to retrieve and select the data, that's a problem.

And, you know paying people to (inaudible) can be very expensive. So, yes, I agree that it's important for us to look at these measures but we also have to look at, you know, again how usable the information is, how retrievable and what the, you know, the actual use burden is going to be for people.

Kristi Mitchell: Hi. This is Kristi Mitchell. I just have one final comment about this. It's around sort of the evolution of where we are in data that's available for tracking, monitoring and quite frankly measure development and use. And so, my question is, all of this is really signifying the need to really begin focusing development around eMeasures.

I mean, if we're looking for a low cost, a low burden, a low cost alternative to particularly using registry or multiple registries and doing chart review, are we not really just talking about how can we leverage EMRs, you know, their electronic medical records to be able to meet the requirement for quality measurement?

And so, I kind of pick issue with the question the way that it's phrased. Should the committee reconsider recommending measures for multiple registries because I don't – I'm not certain that's truly the issue. It's more about, should the committee support the development of eMeasures going forward?

Reva Winkler: Good point. Any thoughts from anybody else before we move on? We appreciate the good discussion because I do think these are important points.

The next theme was raised both prior to your meeting in the pre-evaluation comments as well as the post-comments around harmonization of the medications in related measures. And I think in terms of the measures that are talking about the oral antiplatelet agents (inaudible) after PCI, I think that there was a correction made to the measures as submitted and that was caught

I think early on in the workgroup and I've just kind of given you a side by side.

So, these are certainly do seem to be harmonized in terms of the agents. But the question actually expanded further to talk about all oral antiplatelet agents for other measures, not necessarily specific to PCI.

And I just want to use your expertise in terms of the indications and appropriate antiplatelet agents for patients with other types of heart disease, say coronary artery disease, post MI, but not necessarily a post-PCI.

Are the indications the same for all of the same agents for all of those various patients that harmonization is appropriate or do we need to be careful about the evidence for the appropriate medications for each of those different type of patients?

I guess, I'm just asking some of the cardiologists, are the oral antiplatelet agents recommended for patients after PCI going to be the same agents recommended for patients after an AMI or after a CABG or patients just with coronary artery disease?

Carl Tommaso: It's Carl Tommaso again. There is indication for dual antiplatelet therapy in patients with AMI who have not had PCI, in patients with unstable angina, who have not had PCI. It's interesting, at least the surgeons in our institution do use dual antiplatelet therapy after bypass. And what I've asked them, you know, where is the literature on this? They sort of shrug their shoulders and say, well, we just do it.

So, I don't know in the latter anyway what the real indication is. But certainly, if you look in the – any of the guidelines for AMI or for unstable angina, there certainly is indication for dual antiplatelet therapy.

Reva Winkler: Any comments on any of the committee members? Because as we go through the next round of measures, one of the things we're going to want to focus in on as we look at some of these post-MI or CID type measures is this harmonization. And I just want it to be evidence-based and appropriate. Help us out here.

(Sana Al-Khatib): I could actually comment on this also. I'm the electrophysiologist in the group …

Reva Winkler: OK. So, any help would be appreciated.

(Sana Al-Khatib): So, I mean, the medications are actually the same in terms of data for post-MI and post-PCI. I agree with the comment that's what's made about the post-CABG patients. There, it's not clear because some people undergo CABG without having had, you know, an MI or. So, it depends on what the, you know, what the situation was before the CABG. If they had an acute event, you know, ACS events on definitely in the setting of PCI then yes, dual antiplatelet therapy is indicated and the medications are by and large the same.

Reva Winkler: OK. That's helpful. That'll help us as we get – go to those measures later on, we'll have a sense of when to look for those aspects of harmonization.

OK. If there are no other comments, I just wanted to raise one other theme that was raised and that's around age specifications in the measures. I think it is something that comes up from time to time particularly from our folks with a pediatric perspective about measures including children whenever it's appropriate. But also, one of the things that the comments indicated was the difficulty in identifying the age inclusions for some measures just the way they're described and specified.

So, any particular thoughts from the committee in terms of, you know, age inclusions and did you have any issues or difficulties understanding the age inclusions, the way the measures were described and specified?

Mary George: Reva, this is Mary and I didn't really have any problems. But it seems that it would be good in general for all measure developers to submit some sort of statement regarding age appropriateness of their measures whether there is a specific age, whether it's 18 and up, whether it's (inaudible). But it would be helpful to have some sort of an age indication along with all of the specifications.

Reva Winkler: OK. Any thoughts from anyone else?

Female: I mean, I agree with that comment. Although, if you look at the conditions that we specifically focused on in this cycle, I mean those are conditions that we don't see in children. So, I mean, I think it was implied that we are talking about adults but I see no harm in making sure that the age groups are specified.

Reva Winkler: So, I guess this comment is something all the developers might want to take heed that some of your audience would want the ages more specific in the information about the measures.

Thomas James: This is Tom James and speaking as an internist pediatrician, so I guess I get the younger age group, but so many of the measures are developed by CMS. And CMS is really interested only in Medicare. I've reviewed last night that a couple of the measures related to all cost readmissions some of which are age 65 and above and set others like for PCI, good (inaudible). So, there's inconsistencies in some of these measures. And I – if we can get CMS to say that they're willing to develop a measure which may apply to younger age groups and not just those of Medicare age, I think that would be helpful.

Reva Winkler: I think, Tom, CMS does that for some of – particularly some of their mortality measures where they test the risk models both in the Medicare population and then in all care database as well, but they don't do it universally.

Thomas James: I think you're right.

Reva Winkler: OK. So, we can move on to some very specific – major specific comments for your discussion. And the first one was about the new eMeasure 2473. This is the hospital 30-day risk standard AMI mortality eMeasure.

And there was a comment about the testing of it, noting there appears to have been no testing or validation success to the automatic submissions of such data. And we did get a response from the developer who I think you can read it. They agreed that the testing of the data elements is important and they have tested the feasibility and validity of the data elements across multiple EHR systems.

Results support the ability of the providers to map or extract elements. So, does the committee have any concerns that this comment has raised about adequate testing of this new eMeasure prior to recommending it for endorsement? Were you satisfied with the developer's response?

Kristi Mitchell: Yes. This is Kristi Mitchell and I think I was the primary reviewer for that measure. Yes. I'm satisfied.

Reva Winkler: Thoughts from anybody else? I just want to be sure you're aware of it and have had a chance to think about it. The next measure that we received several comments on is new measure 2450. This is the heart failure measure symptom and activity assessment.

And there were three comments expressing concerns with that measure. One was about the evidence based only on expert consensus. The others include – it's only an assessment and doesn't address what action or appropriate action should – was taken based on the results and our friends from AAFP echoed the concerns about the time to complete the survey as well as issues around literacy for successful implementation. So, thoughts from the committee members?

Thomas Kottke: Yes, Tom Kottke here. I'm still missed the (inaudible) why we voted to endorse this measure when it is – it hasn't been documented to have any association with outcome and it's very burdensome.

Reva Winkler: Thoughts from anybody else?

Thomas James: Yes, Tom James. Do we have a comparable patience experience of care measure that would be a better suit?

Reva Winkler: I don't think so, Tom. I mean, I think what you're talking about are patient-reported outcome measures. And I'm not aware of any that are specific to the heart failure population.

Thoughts from anyone else? You alone – opinion there or are others, some of the committee perhaps thinking the same thing and perhaps you might want to consider re-voting this measure? Thoughts from other committee members?

Linda Briggs: This is Linda. I would say that there were several substantial comments related to that indicator. One was from the American Academy Physicians. There was another one raised by the American Health Insurance Plans that, you know, we might be asking people to do that survey at visits that had absolutely nothing to do with the heart failure diagnosis itself. You know, somebody came in for a sprained ankle or whatever, and they would still be because there is a diagnosis of heart failure on the chart, be responsible for doing this.

So it's adding, you know, some burden and then it was (Phoenix VA) that was talking about the expert opinion. I think these are all valid comments and it is, you know, two large groups, the American Academy Physicians, you know, registering their concern and then the insurance plans themselves actually raising some concerns.

Sana Al-Khatib: And so, I actually agree with the couple of these comments and I remember that those were discussed at length during our in-person meeting, if I am not mistaken (Iliana Pena) was the representative of the developer and we all challenged her with questions about what is the evidence that supports the use of this measure and what have you, and she made the case that like within the heart fail – even within the heart failure community, there is the major gap.

And, you know, assessing and documenting the activity level of the patient and how that's clearly, you know, linked with outcomes and I think that probably largely drove our decision to endorse this measure.

I could see how this, you know, could create issues especially if the visit was not related to heart failure but maybe this could be linked with if the primary diagnosis that a physician bills for is heart failure then that's when you get judged on this measure versus not, but I could see ways by which this could be implemented.

(Bob): This is (Bob) (Inaudible) speaking as one of the developer of the measure. (Iliana) is not on this phone the call today.

I just want to clarify that we're not indicating that one must use a survey, patient-based survey to document the level of activities so it doesn't necessarily be burdensome for the system work or for the patient and one can also use either heart association (inaudible), very simple assessment that the physician is probably already doing is a matter of documenting that in the chart to indicate whether patients have worsening heart failure or (improving) heart failure, stable heart failure.

Because as you've already indicated in the prior discussions at the committee, we thought this would be an important patient-centered measure that is related to quality of life, you know, as well as their outcomes.

Reva Winkler: And so, the question before the committee is, do you want to revote this measure after reviewing the comments or are you comfortable with the decision you've already made?

Sana Al-Khatib: This is Sana. I'm comfortable with the decision that we made.

Linda Briggs: This is Linda. Given the explanations that it doesn't actually requires survey I think that just, you know, comment on the New York Heart Association classification would not be accessibly burdensome. So, I would agree to stand with what we had.

It's Leslie Cho: It's Leslie Cho. I agree.

Judd Hollander: It's Judd. I agree too.

Reva Winkler: OK.

Kristi Mitchell: And this is Kristi Mitchell. I also agree.

Mary George: Mary George. I also agree.

Reva Winkler: OK. All right. Well, it sounds like the committee is comfortable staying where you are but certainly we will include in the report the discussion around these issues.

I think we're getting towards to the end and we should go a little faster but the next measure specific comment was around measure 2459. This is the in-hospital risk adjusted rate of bleeding events for patients undergoing PCI. We just received two comments but one was quite lengthy from Cleveland clinic that expressed concerns that patients may be misled by the results and perhaps be dissuaded from going to high quality centers. There are at least three particular points that they raised about concerns with the measure. Do we have the lead discussant who led the discussion of measure with us?

Sana Al-Khatib: So, I was actually the main person responsible for this measure.

Reva Winkler: OK, Sana. But …

Sana Al-Khatib: Yes, so I mean I saw the developer's response and I completely agree with that, you know, so these are all excellent points that the Cleveland Clinic raised but, you know, in terms of the methodology that was implemented in developing and testing this measure, I feel that the developer did a great job in terms of adjusting for, you know, the case mix and the how sick the patient population is and what (inaudible). I think that is all accounted for.

And then with regard to data validity and reliability which was another concern that they raised, I guess the developer highlighted all the things that they do beyond just auditing because I think the concern here is that, you know, they're only auditing a very small sample of hospitals participating in CathPCI and then honestly these audits cost a lot of money.

So, we can't really expect them to be auditing a larger number of sites although that would be great if they could do that but it's just not doable. But the developer also highlights all the other quality assurance sets that they go through to make sure that the data are valid and reliable. And it's, you know, a work in progress. They continue to work on this and they had a very good publication that after they refer us to with published in 2012 where they really highlight all the quality improvements, you know, measures that they take within the ACC and CDR to ensure data validity and reliability as such, (I'm not concerned).

Female: I have a question. Didn't (Fred Matu) when he presented this data say that he was going to consider some of the valvular patients and their special requirements? Does anyone else remember that besides me?

Mary George: I know this was a – this is Mary and that was the concern that we raised in our discussions at the in-person meeting about those exclusions.

Female: Right, and it was going to be …

Mary George: And I did note that the developer said they will consider …

Female: Right.

Mary George: … for the future.

Female: Has that been addressed or …?

Kristina McCoy: Hello. This is Kristina McCoy. I'm the science lead with the CathPCI Registry at ACC and Dr. (Masudi) can't attend this call today so I can assure you that we did take that or his direction back, we spoke with our data analytical center and they rerun the numbers excluding patients that had what we consider other major surgery. The TAVRs are included in that and we found initially the population that falls into that other major surgery as a minor, you know, 1.5 percent, actually less than 1.5 percent which we also included in our comment.

It is something that when we reevaluate the model, we can also focus on that again but we feel that it's such a minor amount of patient population right now that no immediate changes will be necessary. Plus the bleeding events that we capture are within 72 hours of the PCI. So that might want to be a clinical decision whether you want to take a patient who's had PCI and all these (inaudible) anticoagulants and then move on immediately to TAVR on that high-risk patient population.

Reva Winkler: Any other thoughts from committee members? So, you're comfortable continuing through recommend this measure for endorsement?

Sana Al-Khatib: Yes, I am.

Reva Winkler: OK. Thoughts on anybody else before we move on?

All right. Comment on measure 2379, this again from the folks at AAFP, the use of administrative data for compliance or adherence with issues around drug samples, generic prescriptions in the $4 programs or other concerns throughout the adequacy of the claims data.

We do have a response from the developer that they are not aware that any of the agents are offered at the discount prescription so that claim should not be affected by those.

I know Kyle, I heard you on the phone so if you have any questions, the developer is with us. Who is the lead discussant for this measure? (Inaudible) on the phone.

Female: Was it Jeff Burton, Linda Briggs?

Reva Winkler: Yes, OK. So, he's not on the phone. But thoughts from anyone, could this really kind of springs from our earlier discussion around measuring adherence.

Linda Briggs: This is Linda. I was the secondary discussant on 2379 and recalling our discussion at the face-to-face meeting. We had a long discussion about adherence via administrative claims data and concerns about things that might fall through that wouldn't be reflected in the claims data itself and the AAFP has brought up one of those being, you know, sample drugs provided to the patient.

And while that may be a small percentage of patients for one particular practice, it could be a large number of their patients, if they have a lot of indigent patients and they gave out a lot of drug samples. So, I could see where that could be a concern.

And, you know, as we had talked about before, you know, my concern with the way the Medicare part D is provided, that when patients are in that

coverage gap area, depending on when they hit that gap area whether they submit all of their out-of-pocket information or not, if it gets to be towards the end of the year and they don't perceive that they're going to get to the other side.

They might not submit all of that information and that could affect you know, whether or not adherence is considered because they haven't submitted their individual out-of-pocket that they covered for those drugs during that time period.

Male: Of course, the biggest problem is aspirin.

Female: Yes, right. Because aspirin obviously is not going to be in the administrative claim data because it's been over the counter of prescriptions. But as I recall them, the main indicator for that was actually the P2Y12.

Kyle Campbell: So, this is Kyle Campbell for FMQAI, I'm the measure developer. I do recall aspects of our conversation including the revisions that we made to the measure on May 5th.

One of the things that we discussed with the committee was conceding that we wouldn't specify the measure at the physician group level of assessment and we would limit the measure to the ACO for plan level where some of those differences between practices, you know, would certainly normalize and we would not be dinging an individual practice for, you know, providing samples.

And so, I think that that would – I think that that would really address concerns and there certainly as a precedent in the NQF portfolio in terms of adherence measures being reported at the plan or ACO level like we've suggested for the measure.

Reva Winkler: Thoughts from any other committee members?

Thomas James: This is Tom James again, it's going to be a case that we can only measure through claims data, those who have a drug prescription plan and are on antiplatelet therapy beyond aspect.

By the way, the days of (SES) samples are pretty much behind us now. It's tough to get samples in a primary care office.

Kyle Campbell: Correct. This is again Kyle Campbell for the developer. We are focusing just here on the P2Y12 inhibitor portion of the dual antiplatelet therapy recognizing that we can not assess aspirin. But we do see room for improvement when we evaluate adherence to the P2Y12 at the various levels for which the measure is proposed.

Thomas James: Some NCQA measures will specifically exclude from health plan reviews and this would account for ACOs too. Those people who do not have drug coverage, now, fortunately, that's also getting smaller and smaller with ACA but it's still out there that you got that plans that do not have drug coverage.

Female: Right, but this particular measure was only people that had Medicare part D as I recall.

Thomas James: OK.

Kyle Campbell: Yes, and just to follow up to that and confirm, this does require 11 of 12 months part D eligibility. So, if the patient is not eligible under part D with a plan, they wouldn't be included on the measurement.

Thomas James: I forgot that part.

Reva Winkler: Thoughts from anyone else? Comfortable continuing recommendation at this measure? On versus anybody uncomfortable?

I'm going to take silence as agreement, and we can move on to the last measure specific comment and that is measure 286, this is aspirin at arrival. I recall that this measure is for patients that will be transferred as opposed to patients who are admitted to that specific hospital.

The committee rated the measure low and opportunity for improvement. Remember that we did discuss the possibility of reserve status for measures that are topped-out but otherwise good measures.

And there was a comment from an NQF member asking or stating that they feel there are instances where endorsed measures are still needed and removal of endorsement gives the impression if the measure is no longer a credible, reliable or lack of evidence, in other words, it's no longer a good measure.

I would just want to remind you that reserved status was created to address that concern. And I'll also note that reserve status has been around, actually it was originated in this committee three – four years ago and we have been using it for the last four years. There are not a lot of measures that get placed on reserved status.

And also, I think there are a lot of the measures that were placed on reserve status, have been the hospital measures that have been publicly reported for a long time. And we are seeing CMS removing those from those hospital reporting programs as a result.

They are looking at their topped-out measures as well. We are also going to have a conversation with our consensus standards approval committee later this week on reserve status so NQF wants to look and see what the impact has been and how it's being used and, you know, how we should think about it.

But as this comment really would ask you to think about the decision not to recommend reserve status for this measure.

Who's the lead discussant for this?

Mary George: This is Mary and I was the lead discussant for this. There were a couple other issues in addition to it being topped-out concerning the reliability around probable cardiac chest pain. The measure developers indicated that they were looking towards moving this to an electronic measure and we're somewhat concerned about how reliable it would be to use this measure with electronic medical records. I'm not sure if I know we discuss that on that call before the in-person meeting. I'm not sure if we actually got that far in our discussions at the in-person meeting.

Reva Winkler: Thoughts from other committee members?

Judd Hollander: This is Judd. I don't recall the whole discussion but I do believe we had a pretty robust discussion and, you know, decided that we weren't going to reserve it. And you know, I think we went back and forth with it and I think it's fair for a member to be concerned on that. But you know, I don't see something that's raised new that we didn't discuss at that time and this time I don't believe I'm missing a table that I should have seen.

Reva Winkler: OK, thanks, Judd. Thoughts from anyone else? Does the committee want to reconsider your recommendations not to endorse with measure?

OK, I'm taking silence as agreement. So I think those were the comments that we pulled out for discussion but I would ask the committee as you look through the table of comments, did you see any other comments that you feel needs to be discussed by the entire committee or your – would like to discuss the potential response to those comments?

Female: No.

Reva Winkler: OK. Well, in terms of the actual comments, this is – we've kind of gone through everything that we wanted to on this call today. So, Wunmi, why don't you talk about our next steps?

Wunmi Isijola: OK, great. Thank you, Reva. And before we get into that, we just want to open it up to NQF member and public commenting. Is there anyone else on the line?

OK.

Female: Operator?

Wunmi Isijola: (Brandy), are all the lines open?

Operator: Yes, ma'am.

Wunmi Isijola: OK. Well, with that being said, we'll move forward. Just next steps. Based on the discussion I had today, a lot of the feedback, we will incorporate your responses and your discussion in response to the comments provided.

It will then go into a 15-day NQF member voting period from July 22nd to August 5th. And from there, we will convene during the CSAC meeting in August. We will keep you abreast of all the next steps as it comes to that point in time.

Lindsey, do you have anything to add?

Lindsey Tighe: OK.

Wunmi Isijola: So, we're ending early. Reva, do you have anything else to add?

Reva Winkler: No, I don't have anything and I want to thank everybody on the committee for taking the time to join us today and your thoughtful discussion.

Wunmi Isijola: So, with that being said, we will end the call. Thank you again all for participating.

Male: Thank you.

Female: Thank you.

Female: Thank you …

Male: Thank you.

Female: Bye-bye.

Female: Thank you.

Male: Thanks. Bye-bye.

END