NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
January 27, 2014
2:00 p.m. ET

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

Lauralei Dorian: Thank you. Good afternoon everyone and thank you so much for calling in this afternoon. My name is Lauralei Dorian. I am the project manager of this project. I'm quite excited to be working with a number of you again and also we're looking forward to meeting those of you who are new to the NQF (inaudible). And I will have the rest of our team introduce themselves with you all now.

Angela Franklin: Hello, this is Angela Franklin. I'm the senior director for the project.

Zehra Shahab: Good afternoon. This is Zehra Shahab and I'm the project analyst.

Lauralei Dorian: And I am also very fortunate to be able to introduce two wonderful co-chairs, Don Casey and Gerri Lamb. They have been working with NQF for many years now in the care coordination realm in (URN). I can assure you very capable hands. So I have – I know Gerri is on the call and Don is going to call back in, I think, Gerri if you would like to introduce yourself.

Gerri Lamb: I'll be delighted to. Thank you, Lauralei. Hi everyone, I'm Gerri Lamb. I am from Arizona State University and I have co-chaired care coordination Phase 1 and 2 with Don Casey and I am absolutely thrilled to be working with you again.

This is a very important work and as all of you know because I know that all of you are involved in care coordination work to keep this ball moving forward in terms of measuring what's important to patients and to really to move the needle forward on measurement. It's just so critical. So I was delighted to be contacted about this and I look forward to working with all of you.

Lauralei Dorian: Thanks Gerri. And Don, are you on the call?

Donald Casey: Yes and I apologize for the noise. I hope you can hear me Lauralei.

Lauralei Dorian: I can, perfect.

Donald Casey: It's wonderful to be back. This is actually, I think, my 9th year as part of this steering committee. And we started back in 2005 and, you know, I really look forward to working with all of you and the NQF staff and most importantly my co-chair Gerri Lamb who has been (at) with me, I think, for about five years. So, thank you all and we're going to look forward to today's call which will help you get guidance about the NQF process and a lot of details. So, thanks a lot.

Lauralei Dorian: And now, I'll hand it over to Zehra Shahab who will be doing a roll call of the committee.

Zehra Shahab: First, do we have Dana Alexander?

Lauralei Dorian: And if you could all just, if there (inaudible) give us a few sentences about your background and your interest in the care coordination work at NQF.

Zehra Shahab: Richard Antonelli?

Colby Bearch?

Colby Bearch: I'm here. (Inaudible) in a very noisy hotel lobby in Washington D.C. Can you hear me?

Zehra Shahab: Yes, we can hear you.

Colby Bearch: OK.

Lauralei Dorian: And Colby, did you just say a few words about where you're from and your background in care coordination?

Colby Bearch: Sure. Hello everyone. I'm glad to be a part of this. My name is Colby Bearch. I am – I currently work with an organization here in Baltimore, Maryland. I'm here Baltimore, Maryland. I have been in nursing administration and education for 14 years.

Truly, the company that I work with is a coordinating center. We do a lot of community based care coordination and we've been doing that for a roughly over 20 years now. And so, I'm truly so in love with it and I oversee the Quality and Outcomes Management.

I'm the vice president for that division within that organization. And I'm responsible for a lot of the measures that we look at in this realm. And so, my interest piqued when I saw the ability − the nomination and I'm very happy to have accepted it and to be looking forward to working with each of you.

Zehra Shahab: OK. Jeremy Boal?

Juan Emilio Carrillo?

Juan Emilio Carrillo: Hi, good afternoon everybody. I'm very pleased to be back in this committee. I am from New York. I'm the vice president for Community Health at New York Presbyterian Hospital and an associate professor of Public Health and Medicine at Weill Cornell. I oversee the population health efforts. We have a patient-centered medical home that serve as the base for our care management, care coordination efforts and we have a population-based approach and I'm particularly very interested as well in culture competency. I co-chair the original NQF project on culture competency and had been on several other committees after that. So very happy to be here with all of you.

Male: Hello?

Zehra Shahab: Hello?

Lauralei Dorian: Hi.

Jeremy Boal: Hi, it's Jeremy Boal, can you hear me? I'm sorry, did you hear me?

Lauralei Dorian: Hi, Jeremy. We can hear you.

Jeremy Boal: Sorry, I thought I was muted. My apologies, I am on the call.

Lauralei Dorian: OK. Did you want to go ahead and give us just a brief introduction?

Jeremy Boal: Sure. I'm the chief medical officer for Mount Sinai Health System and a geriatrician by background. I spent most of my career developing care models for frail, vulnerable elderly and dealing a lot with continuity of care and coordination issues. And I'm delighted to participate.

Zehra Shahab: OK. Shari Erickson?

Shari Erickson: Hi. This is Shari Erickson. I'm the vice president of Governmental and Regulatory Affairs at the American College of Physicians. And my expertise is really in delivery system and payment reform. I've done a lot of work within ACP on medical homes. I'm working with folks in medical homes and getting projects up and running to test a model back from we were − earlier and earlier days of testing.

And then my background beyond that is actually I came from National Quality Forum before I came to the ACP and prior to that, had been involved with many of the quality work going on at the Institute of Medicine. So I really view my areas sort of helping to bridge the policy avenues for these measures with the measures themselves and trying to help bridge that gap and identify areas of policy relevance in particular for these measures.

Zehra Shahab: Thank you, Shari. Pamela Foster?

Pamela Foster: Yes, I'm on the call and my name is Pam Foster. I am the director of Case Management for Mayo Clinic Health System Northwest Wisconsin region and have a greater than 20-year background in case management. I'm a social

worker by background, then I worked with this group, the last – on the last effort, on the last committee with − had met a couple of years ago. So I'm really appreciative to be back on the group.

And I have just a very strong interest in care coordination and population health and we're growing, obviously growing those areas at Mayo Clinic and so it's good to be back working with us again.

Zehra Shahab: Thank you, Pamela. Barbara Gage?

Barbara Gage: Yes, hi. I just joined. My apologies for being late. I'm a researcher at the Brookings Institution and have led a lot of work for CMS over the last 10 or 15 years on post-acute care payments quality, episodes of care, a lot of these coordinated care issues in terms of where they go what you need to worry about, hosted a lot of technical expert panels to get input from clinicians at distant level across post-acute care spectrum. Thank you for having me.

Zehra Shahab: Thank you. Dawn Hohl?

Dawn Hohl: Hi, my name is Dawn Hohl. I'm director with Johns Hopkins Home Care Group. I'm also very delighted to be a member of this. My role is I oversee the transition of the patient from a hospice (house visit) and affiliate (into) home care group and a network of many home health and (inaudible) providers throughout the region. So that's my background.

Zehra Shahab: Thank you Dawn. Marcia James?

Marcia James: Hi, this is Marcia James. I am delighted to be in this committee. I am the vice president of Accountable Care for Mercy Health System in Pennsylvania. My background has been on both the payer side as well as the provider side on payment innovation, patient centered medical homes, accountable care organization, and pay for performance.

My role here at Mercy is one of helping the system transform into a population health environment. So, again, I'm delighted to be on this committee. And I'm looking forward to the meeting.

Zehra Shahab: Thank you Marcia. Jennifer Lail?

OK. (Charlie Lagan)?

Brenda Leath?

Brenda Leath: Good afternoon. This is Brenda Leath. I'm a senior study director at Westat where I lead various initiatives on health disparities quality improvement many of which include a focus on performance measure development. I also am the co-executive director of the Rockville Institute which is an affiliate of Westat, Center on Pathways Community Care Coordination. I have over 20 years experience in the health services industry and I have been very much involved in care coordination efforts.

We actually developed some performance measures on a grant funded by the National Institute on Minority Health and Health Disparities. I have strong interest also in population health and I'm delighted to have been selected to be a part of this committee.

Zehra Shahab: Thank you, Brenda. James Lee?

James Lee: Hello.

Zehra Shahab: Hello.

James Lee: Hello. Yes. This is James Lee. I just joined the line. Am supposed to give a self introduction?

Zehra Shahab: Yes. If you could just give a brief introduction, please?

James Lee: Certainly. Hi, my name is James Lee. I was previously with the National Quality Forum on the last review for care coordination. And I'm currently a medical director at the Everett Clinic in Seattle, Washington. And previously I was involved with efforts in terms of community care coordination and also some of the palliative care services in our service area.

Zehra Shahab: Thank you. Russell Leftwich?

Russell Leftwich: Hi, this is Russell Leftwich. I am the chief medical informatics officer for the Tennessee Office of eHealth Initiatives and prior to four years ago, I was a practicing internist and I was on the last phase of this committee and I'm delighted to be working with several folks I know from that previous phase.

I'm also the one of the leads in the Standards & Interoperability Framework Longitudinal Coordination of Care Initiative around improving care transfers and developing standards that are needed for that. And I'm co-chair of the HL7 Patient Care Workgroup which has collaborated with the S&I framework (inaudible) to develop the material and for the update of the consolidated CDA standard that will produce – will result in two new documents, one of which is the care transfer summary and the other of which is the home health plan of care.

Zehra Shahab: Thank you. Lorna Lynn?

Lorna Lynn: Hi. This is Lorna. I'm also delighted to be back in this new iteration of this group. I am a general internist by background. I have been with the American Board of Internal Medicine for about 15 years where I am currently the director of Practice Assessment. What I do with the board is to develop assessment tools to help physicians understand the quality of care they provide in different areas ranging from specific chronic conditions like hypertension or osteoporosis, all the way through to professionalism and teamwork.

And my favorite project for the last three years or so has been developing a practice improvement module for coordination, looking at care coordination between referring and consulting physicians in the outpatient space.

Zehra Shahab: Thank you. Jean Malouin?

OK, Karen Michael?

Terrance O'Malley?

Terrance O'Malley: Hi. This is Terry O'Malley. I'm a internist-geriatrician and the medical director for Non-Acute Care Services at Partners Healthcare which is the large

integrated delivery network in Eastern Massachusetts. I'm the medical director and chair their clinical transitions workgroup, we (spent) about 10 years improving transitions of care and longitudinal coordination of care. I also work with Dr. Leftwich on the S&I Framework Longitudinal Coordination of Care Workgroup. And the standards that are coming out of that group are going to be particularly interesting for us to look at, given their – probably going to be the electronic version of a longitudinal care plan. Thank you for allowing me to be on the committee.

Zehra Shahab: Thank you. Ellen Schultz?

Ellen Schultz: Yes. I'm Ellen Schultz from Stanford University. I'm so pleased to be here. I directed the development of the Care Coordination Measures Atlas several years ago and have continued working on that project and other projects related to care coordination looking at all the various different ways we can try and measure care coordination and thinking to about how you might use electronic health records and other health information technology to try and measure coordination processes. So I'm very glad to be here.

Zehra Shahab: Thank you, Ellen. Beth Ann Swan?

Beth Ann Swan: Hi. This is Beth Ann Swan. I'm the dean of the Jefferson School of Nursing at Thomas Jefferson University in Philadelphia. And I'm here as a representative of the American Nurses Association. And I also am co-leading the care coordination initiatives for the American Academy of Ambulatory Care Nursing. And my personal interest, my professional work collided with reality and the (after) personal care coordination experience. It was really a call to action for me and I've become an advocate for patients and families related to care coordination and care transitions. And I just want to thank you for the opportunity to be part of this group.

Zehra Shahab: Thank you.

Female: Hello.

Zehra Shahab: Is anyone else who has recently joined the call? Who has another chance to introduce themselves?

Jennifer Lail: Yes, hi. This is Jennifer Lail. Can you hear me?

Zehra Shahab: Yes. We can hear you.

Jennifer Lail: OK, great. Hi. We had some microphone problems. I am at Cincinnati Children's in the Anderson Center for Health Systems Excellence and I'm the AVP for Chronic Care. And for 31 years prior, I practiced primary care, general pediatrics, and with a focus on children with special health care needs. And so we're working on quality improvement for our population of kids (inaudible) children with chronic complex disease which are, of course, in both care coordination. So thank you for letting me join in.

Zehra Shahab: Thank you.

Richard Antonelli: This is Richard Antonelli. I found a corner more conducive to hearing and speaking, do you want me to introduce myself?

Zehra Shahab: Yes, please.

Richard Antonelli: OK. So, I actually have a similar path with Jennifer Lail. I started primary – in the primary care pediatric practice in a community in 1987, and then I became what I called an accidental researcher and accidental policy informant when I realized there was no such thing as care coordination but we needed it.

I've had − my current job in Boston Children's Hospital, I'm the medical director for integrated care which really focuses on developing methodology and policy procedures and measures of hand off of care transitions but now just within our hospital system that are prospect community. And most recently had the privilege of being a co-author on the textbook with, I think, Gerri Lamb at some point will bring to the attention of this group, but I'm thrilled to be back for another round of work with the NQF staff and this great group of people.

Zehra Shahab: Thank you.

Lauralei Dorian: Great, thanks to everyone. Thanks, Zehra (inaudible). So we'd really like this call today to be really interactive so we are encouraging you to speak up with

any questions or comments as we go through. The purpose of the call is to orient you to NQF and this project in particular talks about the current project focus, we'll go over the NQF evaluation criteria, which actually will be good even for those of you who have work with NQF in the past because a number of them have been updated in the past year or so. We'll talk about your role, our role and as I said before the measure evaluation process.

OK. So NQF is a private non-profit voluntary consensus standard setting organization − try to say that quickly. We operate under a three-part mission that's meant to improve the quality of American healthcare by building consensus on national priorities and setting goals for performance improvement, endorsing national consensus standards which is what you're here for measuring and publicly reporting on performance and to promote the attainment of national goals through education and outreach.

We are guided by a Board of Directors and a number of committees that sit underneath the Board which is our Consensus Standard Approval Committee or CSAC. We have a number of Member Councils, consumer council, health plans, health professionals, provider organization, public and community health agencies, purchasers, quality measurement research and improvement, supplier and industry.

You might be wondering what consensus standards are. Sort of a fancy word for measures, the purposes, or accountability and performance improvement. A more quality improvement isn't for (inaudible) all quality improvement measures don't necessarily merit endorsement. So this is really an opportunity to ensure that the measures that are considered NQF-endorsed meet a number of rigorous requirements so that why we end up using (inaudible) whether health care professionals or hospitals that they know that they are giving them reliable and valid and meaningful data.

So if you see on the screen in front of you, if you're following along who uses NQF measures. To date, we have endorsed more than 700 performance measures and we maintained these measures to periodic review which is essential to make sure that they are maintained and that they are still relevant years later.

So, most projects here, you'll have a number of new measures that are submitted, but then also what we call maintenance measures which are measures that were previously submitted that are up to undergo review again.

So, here at NQF we have what we call a Consensus Development Process or CDP, you'll hear that referred to numerous times. And I'm just going to talk you through some of those steps. So we've − there's only the call for nomination which is what how you were (inaudible) on this committee that's when we say, so we're having this project and we'd like experts to be seated on this committee.

There's actually been some changes to how we speak (inaudible). We used to do that every single time the project (inaudible) but and I'll talk a little bit more about this later. Now, we've been moving to standing committees so you actually won't have to undergo another call for nomination, again, for three years if you want to (inaudible).

Usually simultaneously, we'll have a call for consensus standard measures and that's when we let the field know that this project was coming and hope that we receive new measures. The standards are reviewed when just starting out with you and we convene you a number of times over call and then as an entire committee later in the year to review the measures.

And then we have a public and member comment here that's very important here NQF that everything we do is very open and transparent. And so our calls are open to the public and we encourage the public and our membership to be involved to new projects.

And so, there's an opportunity for anybody to comment on the recommendation that you've made in the project. We then have a member voting period. And then a consensus as I have mentioned before CSAC. They review all the recommendations finally because the board, the directors and if they agree that the measures are considered ratified and there is also the opportunity for appeals.

And I don't know if that − after the meeting, when you all come together, there's a very official process where you go through a set of criteria and go − and staff summarize those discussion (inaudible) in a report and that sort of what moves forward throughout the project to each of these different audiences.

So measure evaluation criteria that I just referenced have four overarching criteria which are important to measure and report and Angela will walk through these later, with just a very high level overview. And that's where we look to things like to see evidence support and measure focus. We, of course, look at the scientific acceptability of the measure properties, those things like reliability and validity, and we also look at the feasibility of implementing and using the measure and it's current case and (inaudible).

So that ends this project specific information. As you've heard from many of the standing committee members who had been on this committee or worked with NQF in this (inaudible) around care coordination. We actually started addressing the complex issues of measuring care coordination in 2006. And anybody who's on the committee, feel free to jump in, I encourage that.

And when at the time that were actually no sufficiently specified measures at all, so instead there were a number of domains that were endorsed resulting in NQF definitions. You can see those domains in front of you, they're, of course, still relevant but we have some other NQF work that's − I mean other care coordination market that's going on here at NQF that I'll talk about momentarily, whereby the domains are being re-evaluated.

And I've also updated this – not I. We have updated this definition since the original endorsement so that in every care coordination is the deliberate organization of activities and information to help ensure that care recipients and family's needs and preferences of health care and community services are met. So we're really trying to emphasize the importance of reconsideration of things that are beyond the traditional medical setting such as community, community settings and (inaudible) as well.

Male: This is (Inaudible). Can I jump in to this question?

Lauralei Dorian: Of course, yes, please do.

Male: So I'm following along here at the NQF measure evaluation criteria that had conditions for consideration at the top. I recognize that there's quite a bit of legacy attached to that but for those of who'd set up the measure applications partnership, the NQF is sort of moving in this direction of really at the MAP level is guiding the promulgation of work for filling measure gaps, which really applies significantly secure coordination in general.

So I'm just wondering, is it possible to look at this slide to the lens of that was then and this was now, so that we're not doing certain − necessarily condition specificity but being more responsive to some of the gap identification and prioritization of the MAP (inaudible).

Lauralei Dorian: I think that's a great point. And I'll actually talk about this momentarily a little bit and not necessarily as it applies to the evaluation criteria. But there is a lot of work and attention being paid to gap areas now. And I think that there's a recognition overall that when we talk about importance, measure importance in particular, we look at measures of care coordination, how important is it that something, for example, is transmitted to the next provider as opposed to understanding whether it's received. Or how important is it to look at something that's really conditioned in setting specific as opposed to a measure that could be (side) across settings.

So I think that's a great point. And Angela, if you want to jump in.

Angela Franklin: Yes. And I just want to add that in response to the idea that we need to address gaps more proactively − this committee has been seated at the standing committee. We'll take more, I guess, ownership of the portfolio and really focus closely on how we can encourage more development in the gap areas. So as opposed to simply just looking at a list of measures that happened to be before us in this phase, but instead looking at everything in (inaudible) in the portfolio and making some recommendations about where measures fit in and where there is glaring gaps and I know that we have many.

Male: Perfect, thank you.

Lauralei Dorian: Let's jump ahead, (inaudible). So in 2010, and Don was a co-chair on this and so is Gerri, this project. There were a number of measures that were submitted to NQF. Very few of them were actually considered appropriate for endorsement, 10 were endorsed. But instead the committee turns to what we call preferred practices which rather than being measured or ideal approaches or measurements that are out there in the field, and we have 25 of them that were endorsed.

I don't know if, Don, if you wanted to say anything about, it was right before I started about that process or. I'm sure he's not on. But, so we'll be bringing and talk about this as we move forward.

Barbara Gage: And this Barb. What is the difference between a measure and a preferred practice? Are these just not yet tested for reliability but seem like good ideas or could you say a bit about that.

Lauralei Dorian: Exactly. You basically captured it. They're very informal, they're just best approaches that are occurring out there that we want to capture somewhere in our work due to the − particularly in light of the absence of the actual specified measures.

Barbara Gage: But they are being used, they are just the research tool.

Lauralei Dorian: Right, they're all examples of what is actually going on in a field, yes. And it's not typical at NQF to do that, I think, we've might have done it – we did it with safe practices as well, but it's not a common practice. It was just, you know, out of our frustration with a lack of really good measures.

Shari Erickson: Can those be shared with the group? This is Shari − either and I think I picked up on the fact that you guys set up maybe a shared box or something somewhere, maybe if they can be dropped or just (inaudible) for information.

Lauralei Dorian: That's a great idea and we will be talking about that SharePoint website later on in the call. And actually Barb, that you've brought up to our next slide nicely, but we've actually resurrected the preferred practices. There's some more care coordination work going on at NQF that I've alluded to before. I'm

also working on that project. And that's much more of a high level, it actually sits here so that our consensus development market, what we call performance measures. There's another department, strategic partnerships and they're the ones who do the NPP work and the MAP group if you've heard of those.

And so this was actually funded out of HHS, it has five sub-tasks such as workforce, a person and family-centered care and care coordination. The idea is to look at gap in the care coordination area and to make very specific concrete recommendation to HHS to fund the future measure development. So that committee is convening, sort of simultaneously to this one. So we really are making sort of effort to think strategically about this issue, to acknowledge the lack of cross-cutting measures out there now.

And we'll make – we'll continue to operate to keep you aware of that work and be able to be involved in that and vice versa. And the interesting thing I thought was that we've hadn't heard before is that it's actually specifically looking at coordination between primary care and the community with a specific emphasis placed based on understanding social determinant.

So it's pretty new and exciting and in terms of the preferred practices, we actually revisited that preferred practices and we selected ones that we thought were really applicable to this scope of this work and that say could be applied to community setting then and primary care and we revised them a little bit. So I think it's a really great idea to share about with the group. I'll share the original but then I'll also share the recent framework that we've been developing within new language around the preferred processes.

Shari Erickson: OK. Thank you.

Lauralei Dorian: Let's go back to this project in particular. So we have a number of different theme or measures that have been submitted the project. We have transitioned for communication, EHRs, (inaudible) systems and that patient reconciliation. (Inaudible) about measures that you'd be looking at, we have (inaudible) measures from the University of Minnesota and so for example you see their administrative communication and this description underneath that, if you're interested is the percentage of patient transferred to another healthcare facility.

This medical record documentation indicated that administrated information was communicated (inaudible) facility but then prior to the (inaudible). So that's an example and each one of those are different aspect to (sustain) concepts that's being measured.

Terrance O'Malley: Hi. This is Terry O'Malley. Just another question. So within the measures in addition and I suppose they have content to the specified, a certain number of elements under each of those and then probably timeliness and …

Lauralei Dorian: Yes. Yes, and the next sort of step in this project is for us to send you the measures that are submitted and you'll see there are a number of pages where they talk about the evidence, the algorithm, all of their testing. Like you said the time window and exclusion and stuff like that.

So we also have one at least prescribing measure from the city of New York Department of Health and Mental Hygiene. And the description underneath that is of all patients encountered within the past month that's using the EHR with an electronic data interchange where a prescribing has then occurred, how many use the (EEI) for the prescribing event. You'll become very familiar with these measures but just to give you sort of a preview of what these are.

We have three median time measures for CMS. When we actually have one new measure at this phase, we actually had no new measures at all the last time we did a project on care coordination, I guess about two years ago now. And that new measures from (inaudible) health resource center out of the Office of Rural Health in Virginia.

And this actually − the medication reconciliation measures but which we have other (drugs) that looks at an outcome measure so this measure assesses the actual quality of the medication reconciliation process by identifying areas and admission and discharge medication order due to problems with the medication reconciliation process. Target population is any adult hospitalized patients.

So that's the first time we've had a new measure in a while and we're hoping and we're hoping that you'll see as standing committee and for years, you know, and years to come that we'll be seeing more and more of those projects that I had mentioned before (inaudible) recommending to HHS new measure development.

So the − what you've seen (inaudible) is the high level overview of the activity and timeline for this review cycle. The measure submission deadline closed on December 20th so that's where we knew that we have those maintenance measures and then that one new measure (inaudible) in patient. We'll have – you'll be reviewing measures. We'll be sending them to you probably towards the end of the month. That would be early, early February to start reviewing those measures.

We'll be holding workgroup calls. Because we have those few measures, usually we hold four − you might have seen those. Of those four dates, we probably will hold two this time around and that's where you're divided into this group. And we'll divide the measures up. And you're not officially rating the measures but you will begin to discuss them. So that by the time you reconvene as an entire group in March, you're familiar with them. And usually the way that process works is that we will assign a measure or two with that each person. And they can sort of on the calls introduce the measure, the title, the description and then lead a discussion among the committee about what you think about that measure. And we'll offer much more guidance about that process as it nears.

And then you have your meeting on March 18th to 19th, we will draft your report and go through those steps that I have mentioned before such as hosting it for public and member comments then (vote) CSAC, the board and appeal.

Now, to talk a little bit about your vote, it's important that all members, all of you review each measure. So even though you'll be assigned one or two, by the time that the March meeting rolls around, it will be important for you to have familiarized yourself with each measure and participate in that suggestion and votes. You'll evaluate the measures against − excuse me −

each criterion. You will make recommendations to the NQF membership for endorsement. And you'll oversee − Angela mentioned this before − the entire care coordination portfolio of measures. So you'll really be the NQF care coordination gurus and experts and be aware of all of the works (inaudible) here.

So as well as your co-chairs, Gerri and Don are to help facilitate committee meetings. They will represent you at CSAC meetings to keep the group on track, meet goals of projects without hindering critical discussion or input. They will assist NQF staff in anticipating questions, work with us to achieve the goals of the project and, of course, participate as well as steering committee members.

Our role at NQF is to work with you to achieve the goals of the project. We will organize your meetings and conference calls. We'll guide you through the steps of the (CDC) and advice you on our policies. We will review measure submissions as well in comparing certain materials for you to review. We will draft and edit report in your, you know, based on your recommendations and we will facilitate any necessary communication. It really do serve as the neutral conveners so it's important for us, you know, that they truly are your recommendations and we're here to help you out as we can.

So (inaudible), so we also respond to NQF member of public questions, we'll maintain documentation, we'll post that information to the NQF website and the SharePoint page. We also work quite closely with measure developers to make sure that their measure submissions are complete and apprehensive and to answer any questions they have. And we do publish (inaudible) report.

Richard Antonelli: This is Richard Antonelli, if I could weigh in again, please.

Lauralei Dorian: Sure, yes.

Richard Antonelli: So I'd like the answer at the beginning when I had asked about the MAP but it just seems to me especially if this material will become sort of an archive and maybe foundational for the steering committee but it might be nice if that could flash out maybe one more slide sort of falling out explicitly, how the steering committee will relate to the MAP and the various workgroups and

task forces that you had mentioned before, family-centered care population health and the like.

You do call out CSAC which is appropriate but my sense is there are going to be pretty functional interaction between these other entities especially that you'll walk through the MAP. Is that a reasonable request to be able to sort of flash out that kind of content for us?

Lauralei Dorian: Yes. Definitely, quite reasonable at this point and I think it's probably what's left out of the slide deck because, I think it's a new, it's really a new change that's good to hear that we're consciously making that effort to make the connections as much more so than we used to do. So point well taken. We can flush that out more.

Now, I'm going to hand it over to Zehra to go do a brief SharePoint overview with you.

Zehra Shahab. OK. This is Zehra, and as Lauralei mentioned earlier, we will be posting all the documents on SharePoint review and you should've received an e-mail earlier today from nominations with your user name and password and now I'm going to do a quick screen share and show an overview of the SharePoint page.

So as you see, this is the committee home page. And on here we have the current agenda and also the committee guidebook. If you have any questions, you can refer to that and of course, you can always ask us any of your questions as well. In addition, there is committee calendar with the list of dates for the workgroup calls and measure evaluation calls and including the post-meeting call and post-comment calls as well.

The last thing on here that is important to look at also is the committee link. And this is to the National Quality Forum project page for care coordination. And we will add additional links as well to this.

Lauralei Dorian: Does anybody have any questions about SharePoint. I know probably some of you have used it but others have not. But that really will be where we housed all documents related to this project. We're trying to move away from

(inaudible) having a bunch of attachments on e-mails especially when it comes to sending measures, it is much nicer to have a central place for you.

Russell Leftwich: This is Russell. This is Russell Leftwich. For those of us who are on more than one committee or project, will the same log in get us in through everything?

Lauralei Dorian: Yes, it will. Definitely, yes.

Russell Leftwich: Thanks.

Female: And the just to clarify, the focus for the SharePoint is to share the documents. There is not − it's not a place for discussion, is that correct? That will be – occur over obviously during the conference calls, the meetings but also over e-mails. There is other questions or discussion items in between?

Lauralei Dorian: That's fair. So there is a functionality we can put to the discussion board on there. So if it seems like the calls are not enough, it seems as though people really like to be talking offline after the call, we can certainly set that up for you. But as of now, it does not have that function on there.

Female: (Sorry), I just wanted to be sure.

Female: And are we as committee members also able to upload documents? Or do you have limits of what you want up there versus sending to you at NQF and you guys upload that yourselves.

Lauralei Dorian: That's a good question. I know on one of the committees I'm on, external people can upload things and edit them, I don't think for this one are turned on because most of the documents are going to the external, you know, developer submission. But I can look into that because that might be a good idea if there's a report or something like that that you might want me to edit. That would make sense.

Angela Franklin: And also if you all feel like you want to share discussion right now, currently, you can do that by e-mail or shared documents which we've done in other

projects, we've handled it via e-mail. You e-mail us directly and we'll send it out to a committee, that can also be operationalized that way currently.

Lauralei Dorian: And we encourage that.

Angela Franklin: We encourage it.

Lauralei Dorian: Are there any other SharePoint questions?

OK. Well, if you didn't receive that e-mail this morning then just let us know and we can easily resend it to you.

I'd like to turn it over to Angela to take you through the evaluation overview.

Angela Franklin: Thank you so much, Lauralei and also Zehra. At this time we'll dive into measure evaluation overview. And you'll see that the slides in our project are going to be reviewed against NQF current evaluation criteria. I'd like to note that although we are evaluating measures under the 2010 NQF guidance, which haven't really changed. The guidance on how to evaluate the measures has become more rigorous overtime. And so the rigor of our review will be a little bit different than the measures that we reviewed in 2010.

Our NQF guidance is available on the website or we can also post it on SharePoint site for your reference. As Lauralei mentioned earlier, the majority of the measures that will come before the committee in this phase will be maintenance measures. Those are measures that have previously been endorsed by NQF. And however, due to the, again, the increased overview, this doesn't mean that these previously endorsed measures are automatically expected to meet the current criteria.

The page numbers that you'll see at the top of the slide refer to your committee guidebook. And if you have it with you, you might want to get it out and refer to it as several slides we'll be referring to the committee guidebook particularly when we come to the algorithm. There'll be much easier to review in your book as opposed to on the slide.

So starting with our major endorsement criteria as you can see on the slide, there are important measuring report, scientific acceptability, feasibility, usability and use. And if all these criteria are met, the committee will turn to a comparison of measures in the portfolio if there are related or competing measures to be considered.

You can find these criteria again laid out on page 32 of your committee guidebook. And please note that way the criteria and subcriteria are ordered is quite deliberate. The first and second criteria and the subcriteria associated with them are considered must have criteria under our current review guidance. The other criteria are simply less meaningful if the measure doesn't have these first two criteria. And as you can see on the slide, the goal of the important criteria is to measure aspects of measure with the greatest potential of driving improvements. And if these aspects aren't important, the other criteria again are less meaningful on the past criteria.

The goal of scientific acceptability criteria is to make sure it's constructed to valid conclusions about quality, not resource use. Apologies, that's a typo on the slide. If a measure is not reliable and valid, there's a risk of improper interpretation. So this is a must have criterion. We also want to determine if a measure is feasible and that it causes a little burden of practical. And we want to assess whether the measure is useful for decisions related to accountability and improvement.

So even if a measure is feasible if it's not useful, it's not likely a candidate for endorsement. As for the comparison to a later competing measures, we'll discuss that in terms of harmonization and best in class determination a little later on the presentation. So, next slide. Criteria number one, importance to measuring a report. This criterion discussed in quite a bit a detail in pages 36 and 38 of your committee guidebook. And it's just important to note that this is not the same as an important to-do measure.

As you can see from the subcriterion listed on the slide, this criterion intended to determine the extent to which the specific measure focus is important to making significant gains in healthcare quality and improving outcome, determine whether the measure is evidence-based, whether it's focused on an

area where there is a variation or less than optimal performance that is where a gap in performance so an opportunity for improvement exist.

And the measures are ought to be focused on specific high priority and high impact aspect of healthcare. On criterion 1D, quality construct. This is relevant only for composite measures. Currently, we won't be reviewing a composite measure on this project thus far, but the intent of this criterion is to allow developers to tell the story behind their composite by describing the quality construct in terms of overall area of a quality, the component measures that included in the composite, the conceptual relationships between each component of the composite, and the relationship among the components of the composite.

There's more detail on this on page 43, I believe, of your guidebook. But again we don't have this kind of measure in our portfolio for review right now.

When we come to next page which is 1A, Evidence, the subcriterion under Importance to Measure and Report. This subcriterion is intended to address the question of whether there's an adequate level of empirical evidence to support a measure for use of a national consensus standard for accountability. There's a difference in the requirements for the subcriterion 1A evidence depending on the types of measures for outcome measures.

NQF requires a rational which can include evidence but it's not required and the rationale for how the outcome is influenced by the health care process structure. Unlike the requirement for process or intermediate outcome measures. For outcome measures, NQF doesn't require a summary of the systematic review of the empirical evidence that links outcomes to certain processes or structures of care. The reason here is that there are so many processes, structures that may influence health care outcome.

We actually do have one outcome measure in the project for review. So this will be helpful to make a note of. For the process instructional measures, the evidence base, that is the quantity, quality and consistency of body of evidence underlining measure should demonstrate if the measure focuses on those parts of care that are known to influence a desired patient outcome. And

these should be the out – the parts of care that have a most direct evidence of a strong relationship to the desired outcome intended by the measure. And please note that − go ahead.

Female: A quick question.

Angela Franklin: Yes.

Female: So with your point on the outcomes, they did not lead to the evidence base that are slightly easier standards …

Angela Franklin: I'm sorry, what was your last bit?

Female: What was you distinction between the outcome of the process measurement criteria?

Angela Franklin: Yes, for outcome measures, the developer simply needs to establish a rationale between the outcome and the – I'm sorry − between the process and the measure and the expected outcome. And we don't require them to have a systematic review the evidence as opposed to process or any immediate outcome measures.

Female: Thank you.

Angela Franklin: Any other questions on that point?

And if I'm talking too fast, just let me know. I'm trying to get through a lot of material in this short period of time. I'd also like to say that we also − for those of you who want to take a deeper dive, we will be having tutorial calls on Wednesday and Friday. And we just – we'll be able to answer, you know, deeper dive on questions about the evaluation process (inaudible) very complex. So just let me know that as well. Let's proceed through.

So moving on to the next slide, actually – I'm sorry − shall we move back to the evidence base, I'm sorry. For process and intermediate outcomes, there is but one more point I wanted to make which was that − we are − what we refer to evidence in this case, I'm referring to empiric studies. NQF does not

require that randomized controlled trials be the only format evidence that's acceptable.

We're very flexible. The preferred sources of evidence are a systematic review, integrating of a biased evidence that are conducted by independent organizations like the U.S. Preventive Services Task Force or the Cochrane Collaboration, the Cochrane reviews and so forth.

In the case of the clinical practice guidelines that are presented, those are preferably acceptable where they directly support the measure focus. However, we do recognize that the approaches taken to the various clinical practice guidelines vary in terms of the evidence review. In a few cases, NQF also allows an exception to the evidence criterion. But this is an increasingly rare occurrence and we'll cover this one a bit to our evidence algorithm slide.

Again, most of the measures that we'll have will be process instructional measures. So moving on to the algorithm that I mentioned, this is quite an eye test, apologies for that. If we look on your committee guidebook, page 37, you'll se the full algorithm. This is the algorithm that NQF has developed in an attempt to assist committee members in evaluating this criterion. And this is a new approach.

So as we go through our work, please, give us any feedback you may have on how helpful this algorithm has been for you. So, for step one and two of this algorithm, (inaudible) all of green boxes. This will apply to our one outcome measure. First, begin by answering the question of whether the measure is assesses performance on a health outcome or patient report outcome.

If the answer is yes, in box one. Determine if the relationship between the measured outcome and at least one action or intervention is supported by the measured focus, or it states the rationale of the measure. The evidence determination (inaudible) with a yes or no for outcome measures only. If the answer in box two is yes, we move on to the other criterion (inaudible).

So let's move to box three, that's our – the majority of our measures in front of us. And I'm going to focus just on the positive test for the most part so we can

step through a more of evaluation points along the way. And incidentally, these are the parts of the algorithm that are visible on the slide. And it's – again, if there are specific questions about the algorithm, please let us know and we'll be sure to include that in our tutorial calls on Wednesday and Friday.

So, for the majority of our measures process and structural measures, we'll proceed to the blue boxes beginning with step three. And box three determine whether the evidence supporting the measure is based on systematic review in grading of the body of empirical evidence where the specific focus of the evidence specifically matches what is being measured. Often time we've seen some submissions where this is not the case.

So we want to focus the evidence to match the measurements submitted in submission. As you can see, we provided guidance about what to look at in answering this question and it says through of variety of scenarios. And I won't go through − into it there.

Incidentally, if the answer in this box is no, consideration can continue. If there is empirical evidence submitted but without a systematic review and grading of the evidence, that is the determination that close to box seven, that's to be made in box seven. And if that answer in box seven is no, additional determination has to be made but the result, it can only lead to a moderate or low-rating on this criterion not a high rating. That pathway can also lead to an exception to evidence criterion or a stop in consideration of the measure if the evidence is deemed insufficient.

So, that's a little bit of where the exception comes in to play. I'm sorry, go back on – we're still in algorithm. It's quite lengthy, sorry. If the answer in box three is yes, the review it moves to box four and determine whether the summary of the quantity, quality and consistency of body of evidence is provided from a systematic review in a submission form. And we provide some background what we mean by our systematic review for your information here in the algorithm. If the submission doesn't provide this specific information regarding the quality, quantity and consistency of the evidence, the answer to this box must be no and additional analysis can be

conducted in box six. However, that path can only lead to a moderate or low rating of the evidence, not a high rating.

So let's move on to box four. If the answer in box four is a yes, move on to 5A and determine whether the systematic review includes a rating or grading of the quality, quantity and consistency of the evidence. In this case, you can determine whether the grades are high, moderate or low. And rate your evidence accordingly as high, moderate or low.

This concludes review of the evidence algorithm. That's subcriterion 1A. And for our measures, the committee will also evaluate – just a reminder, 1B, the opportunity for improvement, and 1C, whether the measure addresses the high priority. And that's under a completion of review under the important criterion.

Moving on, we are at criterion number two and this relates to reliability and validity of the measure. So the scientific acceptability of the measures and we intend with this criterion to reflect the extent to which a measure is as specified, provides consistent and credible results about the quality of care. The focus here is really the science of measurement rather than the clinical science of the measure. And the basic measurement principles of the liability and validity is what the steering committee will evaluate under these criterion.

Members should keep in mind that reliability and validity are not really all or none properties, they're really a matter of degree. NQF does recognize that reliability and validity are not static and vary with the different conditions of using the measures. And this is where the expertise and judgment of the steering committee really comes into play.

So in reviewing the measures specifically under reliability, committee members should be looking at whether the specs are clear and precise, so everyone using the measure can calculate it in the same way whether there is evidence of reliability, meaning, measure testing, whether that's been provided. And the testing on the data elements and measure score is acceptable, either or is acceptable.

I won't dig deeper into that unless there are some questions about that. OK. Regarding validity, stepping through the validity subcriterion up on the slide, the committee members should also consider whether the specs are consistent with the evidence that's been presented to support the measure, whether validity testing has occurred either at the data element or measure score level. Whether there's appropriate justification for the exclusion, that is, are the exclusions supported by clinical evidence, and the risk adjustment of the measure if it's applicable.

Our outcome measures will need to have an evaluation of the risk adjustment of the measure. And whether there is an identification of differences and performance and whether the comparability of data sources and measures and − I'm sorry − data sources and methods is appropriate. We're basically trying to assess whether the variation between providers that we'll see in the measures (and do) the real differences or whether there is noise in the measurement. We're also trying to consider whether measurement, the measure is actually measuring what it's intended to measure quality of care, and whether the results of the measurement will allow for correct conclusions about the quality of care. Any questions about that?

OK, if there's insufficient evidence, a measure can't be evaluated or considered for endorsement. The measure is considered untested in that case. And however, like I said before, this doesn't replace the need for committee members to bring to bear your expertise and judgment in making this determination.

So moving on, we're at the liability and validity. And this is the slide intended to graphically demonstrate these concepts of reliability and validity. This is also in your committee guide book.

On this graphic, each (dot) is measurement. On the first chart, you'll notice that all the measurements are quite similar but they don't do a good job of hitting that on target. And this portrays measure that's reliable but not valid.

The second target, you'll notice the measurements aren't very close to each other or at the center of the target and this portrays a measure that's neither reliable or valid, inconsistent and wrong specifically.

And the third target, all the measures are close to each other and to the center of the target. And this portrays the measure that is both valid and reliable and measure we like to see and endorse.

Note that in order to be valid, a measure must be reliability but reliability does not guarantee validity. We have a reference in the guidebook for more in depth discussion of this issue and if needed, we can provide the link on the tutorial calls. Next slide.

So just to recap regarding the measure testing requirement, measure developers are required to (inaudible) conducted, empirical analysis which we refer to as measured testing, in order to demonstrate the reliability and validity of their measures. And as noted previously, NQF does allow a variety of methods to quantify reliability and validity. So we're not really prescribing on how this can be shown or quantified by the developers.

Moving on to the next slide.

So, on page 46 guidebook, there's a lot of discussion about reliability testing. The focus of reliability is on repeatability and precision of the measures. And regarding testing, reliability is the measure score refers to the proportion of variation and the performance scores due to a systematic difference, due to systematic difference across the measure entities in relation to random variation or noise as we've discussed earlier.

This is the precision of the measure. For example, statistical analysis of sources, the variation of performance measure scores like a signal of the noise analysis. Reliability of the data elements refers to the repeatability and reproducibility of the data and uses patient-level data. For example, our inter-rater reliability of the measure.

Committee members should also consider whether the testing presented in a submission use an appropriate method and included an adequate

representation of providers in patients and also consider whether results are within acceptable norms. And we get into more detail about that in the guidebook.

And again, these are ways – the ways on the slide that were shown as acceptable for how a developer might test reliability are just a few samples, it could be other ways. Committee members can also refer to the measure testing guidance report for additional discussion. We'll also step through the logic for reliability testing on the second algorithm of (inaudible) testing.

Are there any questions about that so far knowing that we're getting ready to step through the algorithm?

Female: During the orientation calls or whatever is coming up later this week where you will take a deeper dive, are you planning to walk through some examples of exactly how you are applying criterias …

Angela Franklin: Yes. Yes.

Female: … measures that either pass or didn't pass?

Angela Franklin: Yes. I'm glad you raised that. Yes, we will be just – it will be a free online discussion but we will be putting up on the webinar just a copy of one of our measures that we'll walk through and give you good examples about what's expected and what you'll see.

Female: Great. Thank you.

Richard Antonelli: This is Richard Antonelli. And again something that gets kicked around a lot at the MAP and some other forums that the NQF has had been part of is this notion of fit for purpose. It seems to me as though − does that − it seems that that may actually be out of scope for our steering committee because they're actually going to go through this process around usability …

Angela Franklin: Yes.

Richard Antonelli: … feasibility, validity and then at a different level perhaps is the MAP do we get into the evaluation fitness for purpose. Is that correct?

Angela Franklin: That's absolutely correct. You know, but get – that's absolutely correct, Richard. And we won't be specifically making a new determination about that. That doesn't foreclose the possibility of a discussion at the end – at our full steering committee meeting about fit for purpose. But at this point, our focus is really on the criterion.

Richard Antonelli: OK. Thank you.

Angela Franklin: But that is an excellent point. And one worthy of discussion, we will write it into our agenda for that full committee meeting.

OK. So moving on to the next page, we'll take a look at our second algorithm, the guidance for evaluation reliability. So starting with box one, committee members should first consider whether the submitted specs are precise and clear and complete so that consistent implementation can occur. And if not, the rating on this criterion can only be a low.

Moving on to he second box, if the box – answer to box one is yes, you move on to the second box, was empirical reliability testing conducted using statistical test with the measure specified.

Descriptive statistics and explanation subscribing the process, the data management and testing that doesn't apply to or match the measure specs are not acceptable on this box. So if the answer here is no, move on to box three and determine whether testing of patient-level data was conducted. If not, the rating on this criterion can only be insufficient which is not sufficient to pass. If the answer in box three is yes, just use the rating from the testing of the patient-level data elements to rate the criterion that's high, moderate, or low.

Going on to – if the answer in box two is yes, then you move on to box four and determine whether the testing was conducted with computed performance measure scores for each measured entity.

If you have a yes in this box four, go on to box five and determine if that method was clear and appropriate for assessing the proportion of variability

due to actual real differences among the measured entities, or determine whether there is simply noise in the data.

Again, if the answer in box four is no, that pathway has a variety of permutations but the ultimate rating for the criterion could only lead to a rating of moderate or low, not a high rating.

In box five, assuming you move on to box four to five with a yes. If the message was clear and appropriate for second proportion of variability due to real differences among the measured entities, move on to box six where you have a rating of B and C based on the reliability statistic and scope of testing. The assessment here can lead to ratings of either high, moderate, or low working through the logic. And I can't quite see unfortunately through the logic − working through a logic and I have it here, I'm sorry, (inaudible) read it.

And that logic is – my gosh, (inaudible) that open. OK, (inaudible). Page 48. I think I have it here but maybe (inaudible). I'm sorry about that.

So working through box six, you want to determine if there's a high certainty or confidence that the performance measure scores are reliable, that there is – under 6B that there is a moderate certainty or confidence that the performance measure scores are reliable, or under 6C whether there's a low certainty of confidence that the performance measure scores are reliable.

If your determination box six leads to an assessment in box seven, that pathway can lead to a rating of only moderate, low, or sufficient but not a rating of high. So that's the logic for evaluating reliability.

So moving on to validity – validity slide, empiric testing. Again, empiric testing can be at the measure score level or the data element level, we allow either. And face validity is also acceptable and considered as subjective determination by experts that the measure appears to reflect quality of care. (Inaudible) acceptable.

And that bring us to our third and our last algorithm which steps us through the validity logic. Again, the four algorithms in your committee guidebook,

starting out, you would ask the question of whether measure specs are consistent with the evidence provided to support the measure. If not, it can only receive − this criterion can only be rated as low. If yes, you move on to box two to determine whether all potential threats of validity that are relevant to measure – the measure empirically assessed and use specifically be stepping through the exclusions, any risk adjustment that was needed and the ability identifies statistically significant meaningful differences and performance among providers. The various multiple (set) specs and note any missing data or non-responsive to make the determination.

If you determine that all potential threats have not been assessed, you can only rate this criterion as insufficient. If you do find that these threats have been assessed appropriately, move on to box three and you'd ask the question of whether validity testing was conducted using the measures that's specified and that appropriate − that the statistical set has – were appropriate a lot, (inaudible). I'm sorry about that.

Of course, you would answer no, we give you the reasons where you would answer no assessing face validity. Here in empirical validity testing, all your first to clinical evidence or only descriptive facts are given or if there's only an explanation of the process for data management, cleaning computer programming et cetera is presented.

In that case, you would answer no. And then you go through a pathway that leads you to measure or rate the measure as only moderate or low and potentially insufficient. So that's a negative pathway. However, if your answer is yes to box three, move on to assess whether validity testing has occurred – I'm sorry, was assessed with – my gosh, (inaudible) − was assessed with or conducted with performance measures scores for each measured entity.

One overall score for all patients in the sample is for testing patient-level data, that's not acceptable. Then if you determine that validity of testing was conducted as described, you have to determine in box seven whether the method described was appropriate for assessing the sound hypothesized relationship presented in the measure, such as correlation of the performance

measure score on this measure and other performance measures. Differences in performance scores between groups known the different quality are shown or any other accepted measure, acceptable method with description of how the measure assesses validity of the performance score.

If you find a yes to this box seven based on the result, that is the significance and strength and scope of testing, that is the number of measured entities and representativeness and analysis of potential threat, you could make a determination that there's a high certainty of confidence that the measure scores are valid indicators of quality. And you can raise the measures high or you could find moderate, again, and rate it as moderate or find a low certainty of confidence that performance measure scores are valid indicator of quality. That will lead you down the pathway that would ultimately get you to a score, a rating on this criterion of low, moderate, or insufficient.

Are there any questions about rating and validity?

We've also provided in your guidebook examples of what good looks like in measured testing and that's on pages 8 and 11, which gives you a lot of discussion about these concepts.

So moving on to threat to validity. This is an analysis of issues that pose threats to the validity of conclusions about quality of care such as any exclusions, risk adjustments, stratification for those outcome and resource use measures, methods to identify differences in performance, and the comparability of data sources and methods.

This portion of the submission – this is the portion of the submission where developers are expected to respond to questions about how they've got about potential threats of validity and how they assess the impact of these threats on new measure.

So there should be some – there should be some discussion in your submission about these …

(Off-mike)

Male: Hello. How are you?

Female: (Inaudible).

Male: Good, thank you.

Angela Franklin: And if …

Male: Thank you.

Angela Franklin: … people aren't speaking, could you please mute your lines.

Male: Perfect, thank you very much.

Angela Franklin: Please mute your phone.

(Off-mike)

Angela Franklin: Operator, could you mute that line for us, please. Sorry about that.

So we're actually close to the end of our presentation. Moving to criterion three, committee members must assess the feasibility of each measure. And this criterion refers to the extent to which the required data are readily available or could be captured without undue burden and could be implemented for performance measures.

Clinical measures required data elements are routinely, or should be routinely gathered and used during the care delivery process, that is, you know, blood pressure, taken lab test gathered, diagnosis and medication orders. 3B requires – refers to the electronic sources. And here, the required data elements should be available in electronic health records, electronic sources. And if the required data aren't in these electronic sources, a credible and near term path to electronic collection is required to be discussed by the developers.

3C, data collection strategy. This requires a demonstration that the data collection strategy, that is, the source of data, timing, frequency, sampling, patient confidentiality, any cost associated with these, the licensing of

proprietary measure. We want to be sure that these measures can be implemented with the data sources. For example, the data can already be in operational use or testing by the developer demonstrates that the data sources are ready to be put into operational use.

And that moves us on to criterion, page 54 of your guidebook, usability and use. And as you can see on the slide, this refers to the extent to which potential audiences are using or could use performance results for both accountability and performance improvement to achieve a goal of high quality, efficient healthcare for individuals or population.

And you can see the breakdown of the four criterion. The performance results must be used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement. If not to use the time of initial endorsement then a critical point for implementation within a specified timeframe should be provided by the developer.

Then at the end, there's 4B, progress toward improving − toward achieving the goal of high quality efficient health care for individuals or population should be demonstrated by the developer. If the measure is not in use for performance improvement at the time of initial endorsement, then a credible rationale should be presented to describe how the performance result could be used to further the goal of high quality efficient health care for individuals and populations.

And C, the benefits of the measure outweigh the harm, and 4D, transparency. And there's the extent to which the performance measure, performance results about identifiable, accountable entities that disclose an available outside the organization whose performance is measured. So it shouldn't be kind of a black box, it should be very transparent. And these maximal transparency is achieved with public reporting, that's the highest possible transparency.

So, questions that committee members might ask under this criteria would be − has the measure been in use for a while? Is it currently working? Is the measure driving to improve the quality of care? And have things improved

since the measures has been in use? And do the benefits outweigh the harm? Plus, are there any unintended consequences that we may not know about and then the transparency for each of this measure. Then look at transparency for use of the measure for a widespread implementation.

So are there any questions that folks have out there regarding this criterion three and four?

So that moves us then to a fifth, our fifth consideration which would be, after reviewing each measure – each measure has passed all the criterion that we've gone through thus far. Now, the committee has to take up whether or not there are other measures out there, portfolio that are related or competing to the measure that they've just found worthy of endorsements.

If you – if committee members decide whether there are any relating and competing measures and we have a quite descriptive process for that, that we will provide to you as staff to have to step through that. Steering committees are urged to bring there expertise and judgments to the table again to determine how measures might be reconciled and how – what recommendations you might make regarding competing measures, as you can see there.

Are there any questions about related or competing measures?

I would just say, like I said before, staff will lay out, make these determinations early on, will reach out to you, the developers and also alert them to any areas where we see measures are competing or related. And do some fact finding and information gathering for the committee before we present you that decision.

With that said, are there any questions? So hearing none, I'm going to move on to Zehra.

Zehra Shahab: So if there's no question, I'm just going to go and give a brief overview of the next steps. We have two measure validation question and answer call schedule for this week. And those are scheduled for Wednesday and Friday

2:00 p.m. to 4:00 p.m., and you can attend either one of these. You wouldn't have to attend both of them.

Then, in February 19th, 21st, and 26th, we have three workgroup calls scheduled and those are also through 2:00 p.m. to 4:00 p.m. And finally, the full committee meeting is scheduled for March 18th, 19th as of right now.

Angela Franklin: And as Lauralei mentioned earlier, it might be that we only have two workgroup calls, so we'll just keep you posted as developments occur.

Then, that moves us on to …

Lauralei Dorian: That brings us to the end of our call.

Angela Franklin: Yes.

Lauralei Dorian: Thank you so much, we have our contact info up there. Again, earlier today you should have received your SharePoint information, so we'll drop it on SharePoint (inaudible) alerting you when we do.

We appreciate your participation today. We are really looking forward to working with you, really impressive people and I think it's going to be a really good project particularly in light of all of these new sort of work that's just starting.

So I'll call one last time if anybody want to express any final thoughts or ask any questions?

None? OK, well, hearing none then, thank you. We're letting you out a little bit early which I'm sure you're pleased about for the rest of your afternoon and we will be in touch.

Angela Franklin: Thank you all.

Female: Thank you.

Male: Thank you.

Female: Thanks you.

Female: Thank you.

Male: Thank you. Bye-bye.

Female: Bye-bye.

Male: Thank you.

END