**NATIONAL QUALITY FORUM**

**Moderator: Sheila Crawford**
**March 18, 2014**
**2:00 p.m. ET**

Operator: Good day, everyone. Just a few housekeeping announcements for our meeting today. If we could note that all committee members do have an open line for the duration of today's call. So please be sure to use your mute button when you are not speaking or presenting. To reduce background noise, please keep your computer speakers turned all the way down or off, and please do not place the call on hold.

During the secure voting sections of today's meetings, voting members will have the opportunity to click in the box next to the answer of your choice and your responses will be recorded. And now let's get started.

Wunmi Isijola: Thank you, (Shawn). Hello and good afternoon, everyone. My name is Wunmi Isijola and I am the project manager here at NQF. I'm also seated here with Poonam Bal, Zehra Shahab and Angela Franklin, our project senior director.

We just want to kind of take a quick attendance snapshot of who we have on the call today. I know we do have – OK.

So today's meeting is really going over our Care Coordination projects. We are really excited to really undergo and really discuss a lot of the measures that we have in question and I just wanted to give an overview of some of the roles and responsibilities of the standing committee. And I'm sure many of you have already seen this before, but just to kind of reiterate, we do expect you to act as a proxy for our multi-stakeholder membership. I mean, you do bring various different perspectives and we truly appreciate that.

During this meeting, we also will be randomly selecting you all to serve two- or three-year terms. If you do, in fact, have any issues or concerns with that, please let me know prior to tomorrow's call. And during that time, we will be randomly selecting and designating you for your yearly term.

We also anticipate that you have worked with our staff which is the goal of the project. And we really do appreciate everyone. I'm reviewing all of the measures and really taking part of such robust discussion during our workgroup call. And really during this call, we will be evaluating all of the measures against the criteria.

And I know many of you have received my email with regards to some of the algorithms and some of the resource materials to affect decisions. And also, we're asking for you to make your recommendations for this endorsement of these measures, as well as respond to any of the comments during the review period that we will have a factor, as well as responding to any of the direction from the CSAC board and we will provide you with further information post-call, as well as oversee our portfolio.

Angela Franklin: So could we go back to the standing committee roster. So at this time, we'd like to have people on the steering committee introduce themselves very briefly and give any disclosures that you may have. And we will start this with these co-chairs. OK, co-chairs and I'm turning it over now to Anne Hammersmith.

Ann Hammersmith: Hi, everyone. As Angela said, we're going to combine introductions with disclosure. So I will call on you and ask you to introduce yourself and tell us if you have anything you want to disclose. You will recall that you got a rather lengthy form a while ago when you were nominated for the committee, a disclosure of interest form that we asked you to fill out.

For purposes of the disclosure today, please do not recount your resume to us. Please only tell us things that are relevant to what's before the committee. We are especially interested in any consulting work, grants or speaking engagements. But only if they are relevant to the work before the committee.

I want to remind you that you serve as individuals. You do not represent your employer or anyone who may have nominated you for service on the committee. You're on the committee because you're an expert. Another thing that makes our conflict of interest policy a bit unique is that we are interested in seeing other than potential financial disclosures or conflicts of interest. And I'll explain that.

For example, you may have sat on a committee for which you were not compensated, as it may be relevant to something that's before the committee. We would ask you to disclose that. Just because you disclose does mean that you actually have a conflict of interest. We're doing this in the spirit of openness, trying to be as transparent as possible. So with that, I'm going to call your name, tell us who you're with and then tell us if you have anything you would like to disclose.

Donald Casey?

Donald Casey: Good afternoon and welcome, everyone. And we look forward to this site. I do not and have any significant disclosures, other than the fact that I have been chair or co-chair of Care Coordination's steering committee at NQF back to 2005. But no other disclosures of interest.

Anne Hammersmith: Thank you. (Gerri Lam)?

(Gerri Lam): Welcome, everyone. And I'm looking forward to working with you. I do not have any conflicts relevant to the work of this committee, other than, as Don said, I've co-chaired two of the previous committees with him.

Ann Hammersmith: OK, thank you. Dana Alexander?

Dana Alexander: Yes, hi. Good afternoon. So, Dana Alexander, I am a vice president of Integrated Care with Caradigm, which is a population health analytics company. This is my second term on this care coordination steering committee. And I have nothing else to disclose.

Ann Hammersmith: Thank you.

Richard Antonelli?

Richard Antonelli: I'm here. I have nothing to disclose.

Ann Hammersmith: OK.

(Crosstalk)

Richard Antonelli: I am a medical director of Integrated Care, Boston Children's Hospital.

Ann Hammersmith: OK. Thank you.

(R. Colby Birch)?

(R. Colby Birch): Good afternoon, everyone. This is (Colby). I have – I'm the vice president for quality at the coordinating center in Baltimore, Md. I have nothing to disclose.

Ann Hammersmith: Thank you.

Jeremy Boal?

Jeremy Boal: Hi, good afternoon. I'm the chief medical officer at the Mt. Sinai Health System in New York, and I have nothing to disclose.

Ann Hammersmith: Thank you.

(Juan Carrillo)?

Emilio Carrillo: Hi, yes. This is Emilio Carrillo, and it it's a pleasure to be here. I have nothing to disclose. I am vice president for community health in New York Presbyterian Hospital.

Ann Hammersmith: Thank you.

Shari Erickson?

Is Shari Erickson on the line?

Shari Erickson: Hi, sorry. (Inaudible).

This is Shari Erickson with the – I'm vice president of government on our regulatory affairs with the American College of Physicians. And I have nothing to disclose.

Ann Hammersmith: Thank you.

Pamela Foster?

Pamela Foster: Yes, I'm here. I'm the care coordination program coordinator for the Mayo Clinic Health System. And I have nothing to disclose.

Ann Hammersmith: Thanks.

Barbara Gage?

Is Barbara Gage on the line? (Dawn Hall)?

(Dawn Hall): Hi, this is (Dawn). I am director with Johns Hopkins Home Care Group. And I have nothing to disclose.

Ann Hammersmith: OK. Thank you.

Marcia James?

Marcia Guida James: Hi, this is Marcia Guida James. I'm the vice president of accountable care for Mercy Health Systems in southeastern Pennsylvania.

Ann Hammersmith: Thanks.

Jennifer Lail?

Jennifer Lail: Hi, this is Jennifer Lail. I'm the assistant vice president for chronic care at Cincinnati Children's. And I have no disclosures.

Ann Hammersmith: (Charlie Lichen)?

Is (Charlie Lichen) on the line?

Brenda Leath?

Brenda Leath: Good afternoon. This is Brenda Leath. I an a senior study director at Weststat and also co-executive director for the Center for Community Care Coordination at the Rockville Institute, which is Weststat's nonprofit affiliate, currently working on certification, pilot project and have formerly developed community care coordination performance measures on a project funded by the National Institute on Minority Health and Health Disparities.

Ann Hammersmith: Thank you.

Emma Kopleff?

Emma Kopleff: Hi, this is Emma Kopleff with National Partnership for Women and Families. I'm senior policy adviser for the Consumer Purchaser Alliance, which includes the partnership between my organization, National Partnership and Pacific Business Group on Health in California. I have nothing to disclose. Thank you.

Ann Hammersmith: James Lee?

James Lee: Good morning, everyone. My name's James Lee. I'm a practicing internist in – at the Everett Clinic in Seattle, Washington. And I'm also the medical director for our primary care division at our satellite clinic. I have nothing to disclose.

Ann Hammersmith: Thank you.

Russell Leftwich?

Is Russell Leftwich on the line?

Female: Could we see if Russell's line is muted, please?

I know he's on – on this call.

Operator: He is not joined at the moment.

Ann Hammersmith: Lorna Lynn?

Lorna Lynn: Hi. This is Lorna Lynn. I am director of practice assessment, development and research at the American Board of Internal Medicine. I have been the lead developer for a module that ABIM is producing on care coordination, which is in pilot testing and I do not believe presents any competing interest to the work of this committee. And I have nothing further to disclose.

Ann Hammersmith: OK. Thank you.

Jean Malouin?

Jean Malouin: Yes, good afternoon. I am the medical director for the Michigan Primary Care Transformation Project. And I have nothing to disclose.

Ann Hammersmith: Thanks.

Karen Michael?

Karen Michael: Good afternoon. I'm Karen Michael, vice president for medical management with the AmeriHealth Care Trust. And I have nothing to disclose.

Ann Hammersmith: Thanks.

Terrence O'Malley?

Terrence O'Malley: Hi, Terry O'Malley. I'm an internist, geriatrician at Mass General Hospital. Also co-investigator on an ONC-funded grant called IMPACT, Improving Massachusetts Post-Acute Care Transfers, which is looking at care coordination and the exchange of information. And I'm also a co-lead on the ONC longitudinal coordination of care work group within the (ONC-SNI) framework. I don't believe those are conflicts, but they're related.

Ann Hammersmith: OK. Thank you.

Ellen Schultz?

Ellen Schultz: Hi, yes. Ellen Schultz from Stanford University. And I do not have any disclosures.

Ann Hammersmith: Thank you.

Beth Ann Swan?

Beth Ann Swan: Good afternoon. Beth Ann Swan. I'm the dean at the Jefferson School of Nursing at Thomas Jefferson University in Philadelphia. And I have nothing to disclose.

Thank you.

Ann Hammersmith: OK. Thank you.

Are there any committee members who I do not – who joined the call?

OK. Is Russell Leftwich on the call?

Female: She's joining now.

Ann Hammersmith: OK.

Russell Leftwich: They joined me to the wrong call, so I've been …

Ann Hammersmith: Oh, dear. Sorry about that.

Russell Leftwich: I've been in a – very disoriented. Sorry. I am the chief medical informatics officer for the office of eHealth Initiatives. And I'm a co-lead of the (inaudible) framework longitudinal coordination of care initiative and the co-chair of the HL7 patient care workgroup that's responsible for the (inaudible). And I have nothing else to declare.

Ann Hammersmith: OK, thank you.

Did I miss anybody else?

OK. Just a few reminders before you get going.

Thank you for making those disclosures. If at any time during the meeting you believe that you may have a conflict or something that you should disclose, you should speak up as soon as possible. You can do it here in the meeting, you can go to your co-chair who will then go to NQF staff, or you can go directly to NQF staff.

In addition, if you are in a meeting and you feel that someone has a conflict or is acting in a biased manner, we would very much appreciate it if you would bring it to our attention. Again, you can bring it up openly and discuss it, you can go to your co-chair, who will go to NQF staff or you can go directly to NQF staff.

So, in that spirit, do any of you have any questions or anything you would like to discuss regarding the disclosures that were made this afternoon?

OK. Thank you.

Female: Great. Thank you, Ann.

Female: Thank you.

Wunmi Isijola: Thank you again, everyone, for disclosing that information. Just wanted to also let you know that this call is, in fact, public, and it is being recorded. And we do also recognize that we are fortunate to have some of our member developers present, as they will be asked to briefly introduce their measures as they come up for discussion.

But before we go into that, I just wanted to lay out some ground rules for today's meeting. We do ask that everyone has, in fact, reviewed all of the measures beforehand and has provided a basis for circulation and recommendations for all measures for consideration. We do ask to remain engaged in discussions, without distractions.

We do know that some of the measures are – have similar information. But we do also ask that you are concise and focused within each measure, as we talk about each individual criteria, avoid dominating any discussion and allow others to contribute.

Because this is not an in-person meeting, we do ask that you utilize the chat box on your left hand side of the webinar if you have any questions, or should you like to participate in the discussion as well as indicate agreement without repeating what has already been said.

So, with that being said, I will turn it over to Angela, and she will give us an overview of our portfolio.

Angela Franklin: Great. Thank you, Wunmi.

So, just as we referred to earlier in this presentation, we do have a new function for committees, our standing committees, and that is to oversee the care of the care coordination portfolio.

And with standing committees, we're intending to convene our groups of experts who over time become very familiar with both the measures in front of them for current evaluations as well as measures in the topic area portfolio, which we will maintain as a whole.

And we think this will be extremely valuable, as we start to think about identifying and addressing gaps and also harmonizations measures that are coming before us, with keeping in mind the larger picture than simply the measures on the table in front of us at any given time.

So, as you can see on the slide, the responsibilities quickly are to provide care coordination, measurement frame, input on the care coordination measurement framework, which we'll step through in a moment. Also know what measures are included in the care coordination portfolio and understand their importance within the portfolio.

We'd also like you to be able to inform us about measurement gaps that you perceive in the portfolio, and that's an activity that will be informed by the framework and the context that we will step through a bit later.

Also become aware of other NQF measurement activities for this topic area. Be open to external input on the portfolio, which could include comments

from the field on measures that have been endorsed and that are in use, as well as the comments that come in regarding the committee's recommendations regarding endorsements of measures, or re-endorsement of existing measures.

So we'd like to have you also provide us feedback on how the portfolio should evolve, and we'll get into a little bit of that in our – our second day.

And we'd also like for you to consider the portfolio, of course, when evaluating the measures in front of you.

So just to set the stage, we wanted to give you a bigger picture context. And we'll start out, as I'm sure you're aware, with the definition or discussion of care coordination. And as you all are aware, it's increasingly recognized as fundamental to the success of health care systems and improved patient outcome, and the ILM estimates that there's a potential saving opportunity of $240 billion that would result from improved care coordination and initiatives such as patient education and development of new provider payment models.

We do know, of course, that poorly coordinated care leads to unnecessary suffering for patients as well as avoidable admissions, readmissions, emergency department visits, increased medical error, and overall higher costs.

In particular, people with chronic conditions and multiple co-morbidities and their families and care givers often find it difficult to navigate our complex system of care, and – and this group transitions from one setting to another are particularly problematic, and members of this population are more likely to suffer adverse consequences as a consequence of poorly coordinated care. That would include incomplete or inaccurate transfer of information, poor communication across the continuum of care, and of course, lack of follow-up.

So, we'll go on to the next page and give you an overview of NQF's care-coordination work today, which is stretched back several years. In 2006, NQF endorsed the definition and measurement framework for care coordination and we established five domains essential to measurement, including the need for a health care home, the need for proactive plans of care and follow-up,

communication between patients, families, and caregivers, information systems support, and adequate care transitions or hand-off.

In addition to endorsing definition and framework, NQF in its role as convener and partner in the National Priorities Partnership has also focused on care coordination. And just for those who are curious, the National Priorities Partnership is a partnership of, I believe, 52 major national organizations who participate and work together to achieve the three national quality strategy aims, including better care, affordable care, and healthy people and communities.

And, specifically, the partnership established the following roles regarding care coordination, and that is to improve care and achieve quality by facilitating and carefully considering feedback from all patients regarding coordination of their care, improving communication around medication information. They want to work to reduce 30 day readmission rates, and they also want to work to produce personable emergency department visits.

Next slide. Our care coordination work also includes the endorsement of measures. And we tried in 2010, we started with just looking at trying to endorse care coordination preferred practices and performance measures. At that time, we just ended up with 25 preferred practices across the five framework domain. In 2011, we launched this two-phase consensus development process project on care coordination. And the first phase of the project, we wanted to address the lack of cross-cutting measures in the portfolio by developing a pathway forward for meaningful measures of care and coordination by leveraging health I.T. And a paper was developed examining electronic capabilities or the infrastructure that would support care coordination, and also an environmental scan was produced during that first phase, and we were hoping that would lead to more measures coming forth from the field when we convened the second phase of the project in 2012. And, unfortunately, no new measures came forth from the field, and the committee had to review maintenance measures, 15 in total, and selected 12 for endorsement.

Also in 2012, the measures application partnership, which is a public-private partnership that reviews measures and makes pre-rulemaking recommendations for measures to be used in federal programs, as well as worked to align measures across public and private payers. They published a family of care coordination measures and we'll talk about that a little bit later.

And then finally, building on work to date, we have currently going a care coordination gaps prioritization project that's fairly concurrent with our current project, and that work's focused on assessing the status of measure gaps more broadly and is intended to part of the aims and priorities of the national quality strategy by identifying priorities for measurement within the care coordination space.

And we intend, our current standing committee, to provide some input into that work as well, and we have several overlapping committee members and staff and book projects to ensure the work is aligned. And we'll be talking about just a lot more tomorrow, in the second of our (inaudible) committee meeting.

So, a bit more about the phase project. As I said before, there was a commission paper, an environmental scan, and the development of a pathway forward. And we reviewed, and that was phase one, in phase two we reviewed the 50 maintenance measures and resulted in a total of 12 endorsed measures. As part of that project, the committee also prioritized recommendations for care coordination as part of the pathway forward. And that's on the next slide.

So, the committee was concerned about the significant gaps and the lack of cross-cutting components of care coordination within the measures, so they started to prioritize these five concepts they believe could have an impact on helping to move the field forward in terms of measurement. And these include future measure development around patient-reported outcomes such as: did the patient get necessary follow-up care, were the patient's needs met, was care effectively coordinated.

Second, capturing data and documenting linkages. And the questions here were around patient needs and preferences, and it was clear that these misaligned with the relevant interventions in a standard way. And also, there should be a linkage to relevant outcomes for patients. So, for example, if the patient's goal was to die at home, how do we document the relevant interventions to ensure that goal would be met?

Third, we wanted to look at established continuity within plans of care, and around plan of care measures. Committee indicated there should be an initiation of a care plan, transmission between the patients and the providers, and also a receipt and acknowledgement piece and acceptance of the plan regarding accessibility and functionality of a plan of care. I think that's self-evident. Committee found this was very important. And also, measurement of adverse events is important. And, as these could be indicators of poor quality – poor quality care-coordination.

Other themes center on the fact that many of the measures that were viewed in phase two were thought of as maybe fresh-step measures, and the committee was concerned that there should be more measures that could be used to drive and improve practice in terms of care coordination.

So, quickly, these are the framework domains that were established by NQF early on in the game around communication, information systems, care transitions, or hand-off, and those three, those top three, are bolded because these are the measures that are currently before us for review. And also, health care home and proactive plan of care round out the five framework domains. And we have measures in the portfolio around those areas, but they're not up for review in this current phase.

So, just quickly, this is our entire care coordination portfolio. We currently have 24 measures. And just some more context, we've reserved this portfolio for measures that we have characterized as measures that are truly cost-cutting across all our other clinical topic areas in the NQF portfolio. So, these are intended to be relatively pure, if you will, measures of care coordination across all the settings within the health care delivery system that will contribute to improved patient outcome.

And, around communication, you can see the first seven measures are around transitions. They will be up for review today. And we have three other measures around transitions that are not currently before us for review today, and at the end of our discussion of the seven measures, we will have, of course, a discussion about harmonization, and the staff will be stepping you through that. So, on to the next slide.

These are the measures in the portfolio within the domains of information systems and transitions or hand-offs again, with those that are in bold are up for current review. Regarding information systems, we are down to just one measure in this area around e-prescribing. There was another measure in the portfolio, but it was withdrawn, retired rather, by the developer, in this phase of the project. So, there's one in that domain, and we have in this transitions domain, 10 measures currently endorsed in the portfolio. Many have focused on acute care, and E.D. care, timeliness of care, as well as medication, reconciliation and management.

Three of the measures here around timeliness in the E.D. are up for review, and these continue on to the next page. And just for completeness, I included our new submitted measure in this phase, number 2456, around medication reconciliation, and we have, of course, two measures in the health care homes space, and one measure in the plan of care and follow-up domain.

So, just quickly, I mentioned the MAP family of measures. I wanted to give you a picture of the priority topics that the MAP family has identified. And you can see they MAP quite a bit to previously identified priority areas, including (inaudible) missions and readmissions, system infrastructure report, meaning health I.T., medical homes, tracking reminder systems, care transition, of course, in the areas of effectiveness and timeliness; communication, including patient – provider-to-patient and provider-to-provider communication; care planning and patient surveys related to care coordination.

That is the patient experience and perception of care and care coordination.

And that sets the stage for our next work, which was the work of the MAP care coordination family of measures. And the themes that emerged from that work of the MAP were that there should be more measures around personal caregiver engagement, access to community resources, system-wide engagement – engagement, as well as access to data issues.

And we understand there are continuing challenges in the area of collecting meaningful data for quality measurement, as well as challenges in the area of cost – identifying cost of care implications.

So just quickly, these are the measures, some of which are up for review today, that the MAP has included in their family of measures. And they're not all of the measures that are in the portfolio. These are the highest recommended measures for care coordination.

As you can see, we have five of those out of a seven-measures suite that are identified as key under communication, and those are up for review, with the other three transition measures, and the care planning measures, medical phone survey measure and the time – timely initiation of care measures.

Operator, do you mind muting that (inaudible)?

Operator: Thank you.

Just a quick reminder, please don't put us on hold. We usually get (music).

Angela Franklin: So, as you can see, there's still significant gap areas and persistent gaps, which moves us on to our next slide. This is a part of the MAP recommendations that came out in February of this year, where again, identified – identification of priority gap measures for care coordination occurred around these particular areas of communication systems, infrastructure and support, and avoidable admissions.

And here, these are the priority gap areas that the MAP is calling for. The fields bring forth measures to effectively address the issues of care coordination.

So just to tie things up, as you can see, across all the NQF work to date, similar and overlapping gap areas have been identified that (map) to our framework domains, that are at the center of the slide here. And in this context, this is the context in which we are considering measures that place in these domains, if you will.

But as you can see from previous slides, gaps are very stubborn and persistent in terms of measures across settings and measures that really begin to go further to address the domain areas and the price – priority areas of patient caregiver engagement, measures that push forward evaluating (system-ness) versus measuring (philos), and the outcomes measures and composite measures versus individual process and structural measures.

And we do recognize that some of those latter measures are very valuable. So, we are going to, as I mentioned earlier, we have engaged in new work to think about how to begin to fill gaps instead of just identifying them. And that will, again, be discussed on day two of our webinar, when we discuss the measure prioritization committee.

So this is just our North Star, the national quality strategy for reference and context. And care coordination falls within the effective communication and care coordination part of the NQF, which will serve to guide our work.

So, with all of this preamble, this leaves the steering committee to consider the following questions. For example, regarding the measurement framework, does it really facilitate our understanding of high-leverage improvement opportunities? Why are the measures in the portfolio important? Do the measures that we have in the portfolio truly address quality problems? And regarding other areas of care coordination, are additional measures or other measures needed? And if so, how should they – what areas should we target? And are you as steering committee members aware of any measure or concept that could come forward to help fill some of these gaps?

So, and with that, I guess I will turn it over to our chairs, who have also been very involved in many of the activities that I walked through just now. And if

they have any additional comments around these areas, and then move into our measurement portion of the call.

Donald Casey: Well, Angela, thank you. This is Don. Hopefully you can hear me OK.

Angela Franklin: Yes.

Donald Casey: A quick question on the last slide because I know that many of us, folks like Brenda Leath have – have commented in our prior work in this preparation around health care disparities. And I just wanted to call that out because I think it's embedded in – in the priorities, you know, as one example, in the person- and family-centered care but would you just reaffirm that for us, just because I know that's going to be on people's minds?

Angela Franklin: Yes, that is definitely – that is within all of these – within all of these considerations (inaudible).

Donald Casey: Good. Thank you.

So, I just want to, on behalf of this committee, say also thanks to the staff for doing such a great job in getting us today and tomorrow. This has been a lot of work. There's been a lot of back and forth, and the documentation and the support has been excellent. And I think our participation has been very high.

So, it's a credit to all of you and we look forward to working, you know, with you going forward. We have a lot to cover today. And I also appreciate your sensitivity to being responsive to Ann regarding your disclosures of interest. And certainly my experience, and I think many of yours is that in the context of any discussions that occur where things pop into your mind that heretofore hadn't been thought of in terms of the potential for the need for disclosure, I think the rule of thumb, Ann, would be that if there's any question about it, go ahead and at least pose – pose the point of the question.

It sounds like somebody hung up on me already, but would that be a fair request, Ann, of the group as we – as we move forward here, just (inaudible)?

Angela Franklin: Yes. Ann actually had to step away, but yes (inaudible).

Donald Casey: Good, good. So just keep that in mind that we're very sensitive to that as well going forward, but it sounds like the committee has done an excellent job on this.

And (Gerri), are you – are you with us? I think (Gerri) had to step off, but she's going to be back shortly.

Angela Franklin: All right.

Donald Casey: So with that in mind, let's – since I know we're anxious to get through the work here, why don't we step into the consideration of candidate (inaudible) measures according to our agenda. And I have just to mark our time, 3:15 eastern time. I'm sorry, 2:45 eastern time. So we are actually ahead of schedule on our agenda, which is good.

But our goal is to – to see if we can make the finish line here.

Did someone want to say something?

Angela Franklin: Yes. Hi, Don. This is Angela.

So I think, and I was planning to give a few prefacing comments before we got kind of started into the – just a few comments around process and how we expect the conversation to flow.

Donald Casey: Right. So why don't we let Angela proceed then with her (inaudible) the evaluation process. Thank you for that. And I think you're going to show some slides on it, so …

Angela Franklin: Yes, that's right. Well, actually we're just going to be speaking to setting kind of the stage a bit about how we'll proceed through today's call. And we'd also like to set the stage a bit for some of the specific measures that we'll be reviewing. And in addition to our EDI measure, which we'll pull up the next slide. In addition to our EDI measure at the start, we'll be reviewing a suite of seven measures related to patients being transferred between – between institutions.

And we're well aware that several early comments from the committee were about how the measures relate to each other and how they might need to be reported together as a unit to potentially provide the intended results and improve care coordination. And we wanted to let everyone know that we've had some conversations previously with the developer about this both in the work group meetings. And the developer is on the line to answer any questions about those issues.

But I'd like to remind everyone that that would be maybe a future iteration of the measures – of single measures – the one single measure or a composite measure. But for now, we're asking the committee to valuate and vote on the measures as they are in their current form, and that each measure is intended to stand on its own.

And when you're reviewing and discussing as you may have relied on your steering committee guidebook, you may have noticed there are several possible outcomes for any measures including finding exceptions to certain criteria. And we'd also like to remind everyone that the committee does have the opportunity to bring their expertise and judgment to bear in evaluating – in the evaluating process. And NQF really relies on that. That is – that is to say, these algorithms and criteria are not always completely black and white, and there is some room for the committee to discuss and deliberate and that's the value add here.

And again, as Don referenced earlier, at the end of today's agenda we will be discussing harmonization of related measures, and that is any aspect of the related measures that may need aligning and harmonizing so that they are uniform and compatible.

So with that, I guess Don I'd like to turn it over to you and …

Donald Casey: Well, Angela, let me – let me add, just as a reminder to the committee's overview here that, for those of you who have not been part of this, we just need to keep reminding everyone that the process doesn't end with our deliberation, that this actually then sets the stage for the delivery of a – a set of recommendations for voting to the NQF membership.

And then, that will lead to an additional iteration of a very broad evaluation and input based upon the work we're doing today so that, you know, the ultimate decider in this will then follow through once those things are considered to the CSAC and then ultimately the NQF board so that we're really at the first phase of the – sort of finalizing it, as it were, since its development process and that there's going to be a lot of work ahead of us and in the sense of looking at feedback and giving additional input into our deliberations today.

So but this is really the launching pad for the process so we really look forward to it.

I wanted to also, as we address each of these individual measures, be mindful that you're going to be voting in accordance with our usual process on four categories, which would be important scientific acceptability, feasibility and usability – and I think I got that right, didn't I, Angela?

Angela Franklin: That's correct.

Donald Casey: And so the importance is the first hurdle, because if we don't get past the importance part in terms of our consensus, then we don't – we don't then review the rest of these, but that being said, we're going to step through each of the measures in that – in that framework.

So for those of you that are going to be presenting please be mindful of trying to pay attention that order of our discussion and then that way we'll have some consistency here, the measure developers will be with us and they'll be in addition to providing some up front orientation (inaudible) available for brief questions. We're not going to get into a lot of details here, because we already did both on our work group conference calls posed lots of questions and make lots of comments to them.

So this is going to be an abbreviated version. Not everyone on the committee was on both conference calls. So you might have missed some of it. But, we have tried to capture in some background documents some of the responses of the major developers to the questions and concerns raised.

So with that in mind why don't we jump in the air and I'm going to ask if there are any pressing questions for committee members before we begin about the process.

OK, so just as a reminder also if you want to speak up as you're listening to presentations use your chat-send box down at the bottom of your screen so the staff and I can help keep track of sort of who wants to make a comment or ask a question.

I will be today's leader and (Gerri Lamb) will be tomorrow's leader, so you'll get both of us and that's – that's going to be on for it.

So why don't we begin with 0487, which is EHR with EDI prescribing use encounters where prescribing event occurred by the City of New York. And our primary discussion is (Dylan) and (Secretary Colby) and I might ask the city of New York Department of Health and Mental Hygiene to – if they're on – you want to go through these slides that the importance division report? Do you want to remind people or …

Angela Franklin: Sure. This is – this is Angela, just a quick thing, like Don said, we want the developers to give a quick one to two minute overview of their measure or suite of measures to set the stage, and then we're asking our two lead discussants to introduce their signed measures and then just focus on the criteria at hand. So right now, the criteria at hand is importance to measure and report. And then throw the floor open to comments from the secondary discussant who should add any additional comments, but not repeat information, and then throw it open to any additional work group member comments and then the holstering committee.

But, we will remain focused on and vote on each criterion as we go through the measure. And then, Poonam here will tell you more about how the voting will proceed.

Poonam Bal: Thank you, and so as you can see on the screen you would vote by basically clicking little boxes next to either high, moderate, low or insufficient. And that would determine your vote. You can change your vote. But, only once this screen is open. We will have one screen open which has (Exteria) on it

which will let you know what you need – what you should be discussing and focusing on. And then once we finished discussing, I will go over to the next slide, which will have this actual display on it.

And once you see that, you'll be able to vote. And I will give you a heads up, letting you know voting is open. And also, just so everyone is aware it's always considered anything above 60 percent is consensus, so what we're looking for and high-moderate do go together. And if they are 60 percent or higher we will move on tot he next measure.

If they are under 40 percent, it will be considered that it's not a pass and we'll just end with the measure there, and not recommend it for endorsement.

So that's the basic way that the voting will go. If there are any additional questions on how to vote or what your vote will mean?

OK, perfect. So then we can go – also just so you know we do need – certain criteria are a must have so if you – we do not pass – if we don't get at least – I'm sorry, at least 40 percent on them we will not proceed forward and it will end right there.

So then we are ready for the (inaudible).

Donald Casey: Right, and we'll rely on staff to – as we compile these results electronically – then guide you so you don't have to remember all the details. The important thing is for you to really vote with your – your heart in your head about each of these attempts and then – and then we'll – we'll review the results and then we'll both explain that and make decisions about the next steps.

So with that in mind, let them ask those from the city of New York, please identify yourselves and please just briefly help us introduce the measure.

Do we have this group on the call?

Female: Do we have …

Donald Casey: Wunmi?

Female: … Amir?

Do we have anyone from the New York City Department of Health.

Female: Operator, do they have an open line?

Operator: Yes, all the lines are open.

Female: OK. All right.

Wunmi Isijola: OK, we can go on to the next (inaudible).

Angela Franklin: OK, let's move on to the next measure, which is …

Donald Casey: You want to wait for New York then?

Angela Franklin: We'll see – yes, we'll give them some time …

Donald Casey: OK, so we'll move on to the University of Minnesota measures?

Angela Franklin: Yes, yes.

Donald Casey: And, do we have our U of M colleagues on the phone?

Operator are the …

Female: Operator, operator …

Donald Casey: (Inaudible) University of Minnesota with us?

Operator: All the lines are open.

Female: All the lines are – OK …

Donald Casey: All the lines are open.

Female: Do they have …

Female: Can we get some of the measure developer names. We can verify to see if they've called in at all today.

Female: It would be (Jill Moskowitz) – I'm sorry, (Jill) or (Ira Moskowitz).

Female: I haven't seen either on the call yet.

Donald Casey: OK, so it – it looks like we have neither of our measure developers. So let me ask Angela, is it still OK for us to proceed with our discussion and voting without them present at this point?

Angela Franklin: We can proceed with this. Let's proceed with the suite of measures. And we're reaching out (inaudible) there was some miscommunication …

Donald Casey: Right.

(Crosstalk)

Angela Franklin: (Inaudible) some time to join. So with that, we can have the primary and lead – secondary discussants introduce the measure and the comments from the work group.

Donald Casey: And then you'll also try to track the New York (quotes) down too?

Angela Franklin: Yes.

Donald Casey: OK good.

So Jeremy and I are on a hook for this. This is 0291, and just to remind the committee, this is as was referred to as a suite of measures, the next seven measures which would be 0291 through 0297 …

Jeremy Boal: On your agenda on all …

Donald Casey: … from the same measure developers. So, we will be reaching out to him to get them here. But I think in the interest of time, let's proceed. And let me – let me run through sort of my mind's eye on the – on the four criteria.

For those of you that weren't on the call, we did spend a lot of time on these measures. And we had some similar types of discussions about this, so in this suite, I hope that, as the other reviewers present their measures, that their –

they don't necessarily repeat all the details here. But in essence, these measures were designed to fill a gap that was identified by the University of Minnesota Rural Health Research Center.

As you know, there are measures of emergency department transfer communication, which were not applied initially to rural hospitals. So, the goal here was to really create a space for a very important part of the health delivery system from the standpoint of providing both quality improvement and accountability measurements for being sure that patients who presented, for example, to a rural emergency department that then required additional care away from that hospital, i.e., to a secondary, tertiary and quaternary center, had appropriate and timely transfer of key patient information so that the time spent in the transfer would be focused on patient care, and not searching for these things that might delay the care. So, that's what I recall sort of generically as the challenge in the importance of why this was – why these measures were put into place from the perspective of the administrative communication.

I hope you can see the measure worksheet. But in essence, this one is really the communication of essential health care information. And the goal here was to present the administrative information so that, for example, the usual types of information that are given around things like insurance coverage, were available.

There is a challenge with these measures, because they're facility-based, and the – from the standpoint of the scientific acceptability, part of the challenge was that there weren't identified systematic reviews that supported these measures, although there was – there were references in the literature. And one could argue that part of this was because of the small numbers that rural health departments – rural health emergency departments take care of that this could be a challenge from a scientific standpoint. The measure developers didn't take that into account, and believe that the data is valid in the sense of creating numerator and denominator details for trying to measure differences between and amongst emergency departments and rural facilities.

There was both reliability and validity testing that was done in the field. And I'm not going to deal with the details of that except to say that there was pretty good agreement with abstraction in about two thirds of the cases, where this was cross-referenced with the – with the actual physical data at each end of their trans – the transfer.

And so, inter – integrated reliability was tested. And the validity also was evaluated based upon an algorithm that relied upon face validity. So, in other words, the evaluation of the information was reviewed by an expert panel in terms of trying to make decisions about whether there would be concordance with professional standards.

There were limitations on this. The feasibility was also, I think, demonstrated in the sense that there wasn't an expectation in the implementation of these measures that there was undue burden on the facility to collect it, although in the beginning, there was a need to get data standards – and this is back in 2007 – were appropriately put into place.

And ultimately, from a usability standpoint, there was also, I think, pretty good response from rural health centers that these measures were, you know, in the end, helpful in terms of identifying and pointing to opportunities for improvement.

So, those are sort of my general comments. I'll ask my secondary discussant, Jeremy Boal, to add – (chime in) anything else that is important here.

Jeremy Boal: Sure. I thought that was an exceptional review. And I agree with everything you said.

Just going back to criteria number one, importance – while it may be that this measure doesn't strictly fit the NQF acceptability with regard to importance, it – I think it's very difficult to argue against its inclusion in the context of the rest of the measures in the set. I know we're supposed to look at this in – in an – in isolation, but it – it really is a precursor for everything else.

Donald Casey: Right. So, since I'm also the chair here, I'm going to ask them to – the committee members – well, before I do that, did we get (Yuvem) on the line yet?

Operator: We are contacting (inaudible).

Donald Casey: Still working on that.

Well, let me ask the committee for – especially those that were on the first work group – to add any other thoughts or comments about – about what's been presented and what you had before you.

(Gerri Lam): Don, this is Gerri. I'd like to …

Donald Casey: Oh, hi, (Gerri).

(Gerri Lam): … make a couple – I'm back.

I think that Jeremy's comments really are the crux of the issue with this – not only with this measure, but with the suite of measures – is in the are of importance, that it does fill a gap. And I guess what I'd like to throw out is, it fills the gap for the rural areas, but the measure developer also, I think, shared with us during that call that the expectation was, as I.T. systems develop, that they expect that the need for this measure, or measures like this, will – you know, will no longer be needed.

So, we're talking here – and I'd just like to throw that into the dialogue – is something that has emerged to meet a gap, but is not expected to be long-term.

In terms of the importance, the strength of the evidence, as both of you have said, is relatively low. It's hard to challenge the face validity, but the evidence offered is low. And so that – I – you know, one of the questions that – that we need to raise is whether we need to do – if we wish – to do an exception, because that is a required element of the review in terms of moving forward with the other review.

Emma Kopleff: Hi. This is Emma Kopleff from National Partnership for Women and Families. And I need to add, for those who weren't on the (initial) call, I think

we summarized that the importance criteria wasn't necessarily met, but there's some nuance there. And if I might just add some of the details around why that importance sort of failed – again, you know, we just commented – we just heard comments about the measures potentially becoming obsolete.

I think the literature view that was noted earlier didn't particularly meet the NQF criteria for a systematic review of graded literature. And the literature also sort of spoke to some of the more general issues faced by rural hospitals, but wasn't necessarily applicable or directly relatable to patient outcomes.

So, my two cents on that call was, which I'll repeat now, has been that was sort of a struggle for me in understanding the importance for the consumer population, and, to the point, about the measures becoming obsolete in the next few years. To me, that does speak to a signal to focus our measure development in endorsement resources on measures that raise the bar a bit more. And then – then simultaneously, look for ways from a quality improvement perspective to push on the development of those HIT infrastructure support. I know that's beyond the scope of this committee, but thank you for the opportunity to share that.

Donald Casey: No, Emma, those are – those are really important comments. And one thing that was brought up in the call was – was the question of how these were starting to track with meaningful use evolution, as I'll call it. And the measure developers actually did provide a – somewhat of a crosswalk of each of the data components with – with where we are with stage 2.

And I think, as (Gerri) pointed out, you know, this is – we're in a transitory phase here, so the question that I think we're going to have to ask is, while we're moving into this – into this more modern view of how information gets transmitted, what are going to do in the meantime.

And just as a reminder of my own view here, I also did note that the developers were in the process of updating the evidence vis-à-vis, some of the evaluations that have been underway for which, unfortunately, did not make it into the measures submission because they weren't prepared. And I think it's policy that once the measures submission is made, it can't be updated, but I

think the researchers have said that they were trying to do whatever they could to gather additional information. And I believe they've submitted – when they submitted their final comments, there wasn't much more to add at this point in terms of the data, just because it's lagging their ability to collect it and analyze it. So these are kind of our states of nature, as (Gerri) pointed out. So other comments or questions?

Terrence O'Malley: Hi, this is Terry O'Malley from partners. Just …

(Jill Slinger): Hi, this is (Jill Slinger). I'm sorry. I was – I had the wrong day down.

Donald Casey: Oh, is this (Jill)?

(Ann Hammersmith): (Jill), thank you for joining.

(Jill Slinger): Yes, this is (Jill).

Donald Casey: Is that (Jill)?

(Jill Slinger): Yes, this is (Jill).

Donald Casey: Hi, (Jill). This is Don. You might have a little echo, so you might want to use your handset. But I'm going to let Terry talk right now, since we're in the middle of our discussion, then we'll get back to you, OK? Thanks for joining.

(Jill Slinger): OK.

Terrence O'Malley: Hi. This is Terry. I have a couple of comments. You know, I think announcement of the death of – before it's born, might be premature. I don't think this is going to become obsolete at any time. I think what will happen is we'll measure it more easily, because we'll be tracking it electronically. But our measure focus will probably shift to make sure that it's complete and that the information that's sent is accurate. Because right now, what we're – we're not asking really either of those questions of these data sets. We're asking are they sent. And I think that this measure will evolve over time. It's a good place to start and I have no doubt that the evidence will accumulate to demonstrate how important this is to safe and effective care.

So I would – you know, I'm willing to hold off on saying they didn't meet the evidence criteria, based on just sort of the face validity of this measure and the accumulating evidence that is out there. And then just recognize that this is going to be the foundation, I think, of a whole series of measures. So we might want to make sure this foundation is well construction, because I think you could see where this could go quickly to condition-specific data sets, medication-specific data sets, as well as honing in on just the absolute minimum information that the receivers need to get. So thanks.

Donald Casey: Thanks, Terry. And I would posit that these discussions (inaudible) are going to end up being related to our other six measures here. So other committee members …

(Gerri Slinger): Don, this is Gerri. I have …

Donald Casey: Yes, Gerri.

(Gerri Slinger): I have a question on that. You know, I think Terry makes a really good argument. I just have a protocol question. When we are rating important in terms of what Terry was saying. and say, for instance, we agree with that, do we rate important in the way that it actually is on the algorithm and then go to an exception or how do we handle that?

Female: We would have to rate it according to the algorithm and then have discussion by the full committee, a consensus by the full committee, that there is the need for an exception, and then go to a vote on that. Thank you.

Donald Casey: Thanks, Gerri. Other committee members?

Richard Antonelli: Don, this is Rich Antonelli, if I could weigh in a little bit. And it's probably built on with a little bit of Gerri and what Terry just said, and this is speaking about this notion that, you know, we are being asked to approved something, but we know that eventually that it's going to – I'll just use the word sunset. And I guess I'd like us to think about some of the underpinnings for what the sunsetting mechanism would be. Now one component of it is as we move for more efficient electronic communications and that's fine, that's something that we're doing. I agree with Terry's observation that this is a good place to start.

But what I want to add, though, to this conversation is something that I thought was nicely captured in the minutes from our last workgroup meeting, which that notion of the handshake. And I think it's really important for this steering committee to be thinking about, you know, what kind of a signal would be sending to the measure development community broadly and then also up the chain at the NQF. If we keep sort of endorsing, unidirectional handshakes as measures of care coordination, that it's intended to be a general statement so it's not specific to this particular measure and I'm not saying we shouldn't' endorse it.

But there are a couple of reasons that I'd like to kind of see this level of – I'll call it rudimentary measures of care coordination. In this case, unidirectional data transfer, that we need to be mindful of what we're looking for so we can set that bar a little bit higher.

Donald Casey: Yes, another other questions or comments? Good point, Rich.

Ellen Shultz: This is Ellen Shultz from Stanford. I very much agree with the previous two comments. I do have a question. So I'm sorry if I missed this somewhere in all the measure documentation. But is this measure intended to be used only for rural or critical access hospitals or is it intended to be used widely? I bring it up because, you know, we've discussed how this fills an important gap in having a measure that can be reported even for small hospitals where they don't have a large denominator. So I'm wondering how much to consider that if this is something that's applied across the board, regardless of where the hospital emergency department is located.

Donald Casey: Yes, so Ellen's question, is is the measure still intended to be specific for eligible overall hospitals and critical access hospitals, as opposed to a broader community. Right, Ellen?

Ellen Schultz: Yes, exactly.

Donald Casey: Yes. (Jill)?

(Jill Slinger): This is (Jill). And the measure can be used across the board, but small rural hospitals and small, you know, community hospitals are the ones that have the most transfers because they have the gaps in services in specialties that are available. So in the denominator, it doesn't say specifically where, it doesn't say specifically small. So whatever hospital feels it's appropriate for them to use it, it would be appropriate to use that because we haven't specified it, because we haven't specified it or excluded any.

Now the general use right now is in small rural hospitals and in critical access hospitals. And (Jill), the validity and liability testing and the comments regarding feasibility and usability relates to the evidence generated by those measures specifically for the rural and critical access hospitals.

(Jill Slinger): That is correct. Our testing and development have all been in conjunction with rural communities and small critical access hospitals.

Donald Casey: Does this then help Ellen?

Ellen Schultz: Yes, thank you.

Angela Franklin: And Don, this is Angela, I just wanted to make sure we were still kind of focusing here on our evidence piece. And you understand that we'll have some discussions later on about the other parts of the measure?

Donald Casey: That's right.

Angela: So we're going to really focus now on deciding the importance and let's limit to that at this point. Are there any other questions or comments about the importance question here?

Emma Kopleff: Maybe it would be helpful if we, given this is sort of a first measure.

Donald Casey: Who is speaking?

Emma Kopleff: Oh, I'm sorry. This is Emma.

Donald Casey: Thank you.

Emma Kopleff: I suppose another suggestion or question regarding profits. Given Gerri's sort of focusing for us on the algorithm as a first step, again, recognizing there may be other points that have been captured in our discussion or will need to be, could we perhaps walk through the algorithm as a group for this first measure and hopefully that would to any others in the set?

Donald Casey: For the importance?

Emma Kopleff: Yes.

Donald Casey: Yes. Yes. So I think Angela has got that up on the screen here, right?

Emma Kopleff: As evidence.

Donald Casey: So we would be pulling the …

Emma Kopleff: Just going to pull up the algorithm. And again, this is the guidance for evaluating the evidence algorithm. And we're going to pull that up on the slide for you shortly. And to be fully transparent, I'm asking that question, this is Emma Kopleff again, from the perspective that, frankly, I – you know, I appreciate the comments about the purpose of these measures now and moving forward, perhaps, for quality improvement.

But as far as the important criteria go, what Rich said earlier really resonated with me about the borrower settings or quality measures, coming from the consumer lend (inaudible) even like to see one day, you know, the transfer of information and receipt of information integrating the patient as part of the transfer of that information, based on patients having online access. But I egress from an important perspective, I felt like I couldn't figure out how this could pass the criteria and there may be others who view that it did, and that would be helpful for me to hear.

Donald Casey: Right, right. And remember, we have a process for dealing with the system.

Emma Kopleff: So we have the algorithm up. And this is a measure of that category (inaudible) in box three, actually. And OK, so you might be able to see that. It's a little bit small. It's also in your committee guidebook. And starting on

box three, the question we're asking is, is this measure based on a systematic review and grading of the body of empirical evidence, where the specific focus of the evidence matches what's being measured? And evidence would mean empirical studies of any kind, and the body of evidence could be one study (inaudible). The systematic review may be associated with a clinical guideline as well.

And so, I will just sort of open to the committee for discussion about that point.

Operator: Any questions?

Female: I guess my question is Emma, did you want us to walk through this in terms of how you go through the algorithm?

Emma Kopleff: No, especially not if others don't think that's helpful, thanks. What I guess, what I am proposing, and I'll be more forthright about it is, is my assessment of this first criteria in box three was no, and so as I went through this, I kept getting, you know, put over into the box of rating the importance of no path. And I just wanted to clarify through the nuanced discussion we've had today that that's where everyone has landed. It's not – it'd be good to hear the other side. And if that is where everyone's landed, how do we proceed forward?

Male: So –, I just want to be clear, you are concerned that they're making a lack of clarity as to what a yes or no vote might be in the first step, or …

Emma Kopleff: I guess I'm wondering if folks, there are some folks that feel we could vote in support of this measure based on this algorithm. Just 'cause I'm trying to be clear, that's not where I'm at, but I know I want us to work through this as a group, not trying to throw a wrench in the process.

Male: Right.

Female: Right. So, another way to think about is just first to go back to our importance to measure and reports slides, our evidence slides, and walk through that. And, I think we've heard some thoughts from the committee about where they're landing on this, on the evidence point. Quality, quantity, and

consistency, and the steps below as that would lead you to a rating of most likely moderate, low, or insufficient, and the question, I think, will become will we choose insufficient evidence with the section, or simply insufficient evidence?

Male: Right, so, I have a suggestion and that is that Angela, if you're OK with this, why don't we proceed with starting the voting process to be sure we've got that up and running.

Angela Franklin: Right.

Male: And then, let's – let's walk through it, knowing that the staff will help us if we come out at the end at a point where we – we didn't – we didn't end up where we wanted to because the process, we didn't think was working properly. I think I've got enough reassurance that we still have a chance to have discussion depending on where we end up, so trust the process is what I'm saying. We – we won't be closing any doors is what I'm getting. We'll still have a chance to discuss what, if anything, to do next, OK?

Let me ask (Jill) if she has any – any other comments other than what you've submitted, (Jill), and what we've discussed on our calls militant to our discussion on this on this one.

(Jill Slinger): Yes, in terms of the evidence of the importance, I think we have primarily used expert opinion and our – the critical literature review is old. And, you know, we acknowledge that, and we didn't have time before this meeting to do a repeat of the literature. I think being familiar with the literature, I know that these kinds of communication elements are important, generally speaking, are the ones for this first one, and again, because I came in late, is it – are we just talking about the first one, are we talking about all of them?

The first one has to do with arranging for a bed and making sure that the physician is accepting the patient, and this one was built really to encompass the (NTALA) requirements, so is this one important to measure and report as far as the quality of care for the patient? Yes. (NTALA) is just saying, you know what, it's a law, and they made the law because they felt that it was an important piece. But again, the expert opinions supported that, and so, if

we're just talking about the first one, that – that would be my comment on the importance of it and the evidence that supported that.

These are process measures, they are not outcome measures. They are not structure measures.

Male: It is just the first one, (Jill), and I did also mention before you got on that you had been in the process of doing a repeat evaluation of the – of the published evidence, as I'll put it, and also are in the middle of or in a stage of evaluating your own data that would lead, potentially, to the addition of new evidence, but unfortunately, given the time frame for the measure submission, I don't think you were able to generate that, so we can't rely upon an expectation of that yet, vis-à-vis what's before us.

(Jill Slinger): Right. And the (inaudible) recently did, recently started requiring these measures starting in January of 2012, and it was – we were consultants on the project, but we do not own the data. And so, right now, the state owns the data and they are not releasing it. Also, our QIO (inaudible) is working on an eight state pilot fronted by CMS as a precursor to the use of these measures and (inaudible), and they have some data, and they will do the analysis for us, and so we haven't gotten those results back yet, in terms that – that the improvement that have been made, the usefulness, and things like that. So, yes, I apologize, the timing isn't always right.

Male: Right, so, if anyone has any additional questions or comments before we, Angela, move into the voting?

Angela Franklin: Yes, this is Angela. I just wanted to – everyone to be clear that as we will be voting on this evidence criteria, it is indeed a must-pass criteria, and if we decide that the measure does not meet the criteria, and then we decide to invoke an exception, we'll have to walk clearly through that – that decision, as a algorithm. And if we want to do that now before the vote, that might be kind of – I guess, we'll have to do a straw poll in that regard.

Male: Well, you know, why don't we – why don't we try to vote, and then, with the mind that when we get to where we get, we will fix the clause and (inaudible).

Angela Franklin: Right.

Male: Any final questions or comments before we get to vote here?

Angela Franklin: Did we want to look again at the algorithms for the exception before we start voting?

Male: No, I think we can go ahead and vote.

Poonam Bal: Voting is open.

Male: So, you have in front of your screen a checkbox thing. Let's …

Female: Yes, and Poonam can walk us through this.

Poonam Bal: Yes, so just make sure that you click on the little white box next to whatever you choose, and we're just going to wait just a little bit of time and see if we get all the votes in.

Male: Poonam, are we supposed to see an X on our screen if we click it or how to …

Poonam Bal: Yes, don't push the X, though. You will be able to see the X.

Male: But, if we press it more than once, I'm just trying to.

Female: If you check the box next to the answer, sorry Poonam, didn't mean to step on you there, it should put a check mark in your box.

Male: Got it. OK, good.

Female: Poonam, actually, your screen is the only one that shows the X.

Poonam Bal: OK. Perfect. This last chance to change your vote, and we're going to do the count.

Female: This is (inaudible). I might have voted three times, then. I thought it was going to show us the X once we hit the X.

Poonam Bal: That's OK. Every time you vote, it'll show up as a new vote. So, your vote only counts once.

Female: OK. Super. Thank you.

Male: On your screen. So, you can change it before we call time, so.

Poonam Bal: OK. At this point we're going to close voting, and the final result is zero high, two moderate, one low, 17 insufficient with exception, and one insufficient, so we can move on to the next measure. I mean the next criteria.

Male: With exception, OK.

Female: Don, may I just clarify something? And I think this was clear, but I just want to make sure, is that when we raise as insufficient with exception, our vote is indicating that we are willing to move forward in the absence of empirical evidence, is that right?

Male: In – in the, I think the absence of empirical evidence might be – with the feeling that the evidence is insufficient, I think is the way …

Female: OK. Because, I'm reading – I'm reading directly from the algorithm is that this is basically, if people are rating – rate is insufficient with exception, they are willing to overlook the lack of empirical evidence and move forward.

Female: That is correct.

Male: Right.

Female: OK.

Male: OK. So.

Female: So, to Gerri's point, does – just to – just to be clear – sorry to interrupt, Angela – this is an agreement, in Box 12 of our algorithm, that the steering committee feels that it's OK or beneficial to hold providers accountable for performance in the absence of empirical evidence of benefits to patients.

And then there's also some language that we should consider regarding potential, you know, focusing attention away from other more impactful measures – this measure whether there's really – cost justifies more costly measures without benefit if we choose this measure, and whether there are any other potential detriments to endorsing the measure.

(Gerri Lam): (Dawn), the reason I was asking that is, I was just wanting to make sure that – that since so many of us voted for the override …

Donald Casey: Right.

(Gerri Lam): … that people understood that they were voting to override the lack of evidence by voting that category.

Donald Casey: Right. I – I just – does anyone – does anyone not understand that?

(Dawn Hall): Could – could you review that again? This is Dawn. Thank you.

Female: Sure. Sure.

So, the vote exception means the committee agrees that it's OK or beneficial to hold providers accountable for performance in the absence of empirical evidence of benefits to patients. And the committee's considered the potential detriment to endorsing the measure. For example, the detriment of maybe focusing attention away from this area for measure development that may be more impactful.

Donald Casey: Does that help, Dawn?

Dawn: Yes, thank you.

Emma Kopleff: And – this is Emma. The point you just raised – I know that was (inaudible), Angela, but that has been my concern – that the opportunity to sort of press on these measures and have a similar measure that indicates receipt of information, for example, would no longer become – remain a priority, given that there's an existing measure in this space.

(Jill Slinger): Let me just say that the – receiving information would – as – as the other person – this is (Jill), I'm sorry – is more – at the tertiary hospital level. And so, where they never would transfer someone out, a rural hospital would rarely receive a patient to receive that information.

So, that they would be in adjacent spaces, but would not supplant each other.

Male: Angela, do you have any comments for Emma's (inaudible)?

Angela Franklin: No, we just wanted to be clear for the record.

Male: Right. Right.

Terrence O'Malley: Hi, this is Terry O'Malley again. I just – just to the last speaker's comments. You know, I – I think – and to Rich and (Nelly's) comments – we – is there a way we can – is there an amendment structure process? Just to make sure that the bidirectionality of this exchange, and the acknowledgment and the opportunity to ask questions so we get staked into the measure somewhere.

Thank you.

Male: Terry, I think the measure is what it is. I – I'm not aware that that's been clarified or not. But we have to – we have to take what's in front of us, and I'm not – I'm not – I don't think that has been clarified in the process.

Angela Franklin: Yes. And, Dawn, just to add on – this is Angela – the measures are as they are before us, but the committee does have the opportunity to record, you know, its recommendations and comments around the measure that will be included in our public report.

Male: That's right, but – but from a voting standpoint, you got to take – take what it is.

Angela Franklin: That's exactly right.

(Richard Antonelli): But I think – this is (Rick Antonelli) – I think we should take advantage of that comment – you know, maybe begin that parking lot now, because I think

everybody on this call recognizes the path before us in terms of moving the (field).

So, I think if every – so for me, it actually winds up being a bit liberating for me to be thinking about these measures, and then putting in some directionality about where we want things to go, going forward.

Male: Absolutely.

So, why don't we go ahead now and move on to ports to measure report to the next step here with performance gap?

And this is as you see it on your screen, including disparities.

Angela Franklin: So, here we would open (inaudible) for a discussion if (inaudible) performance gap. Hopefully, comments from the work group, comments about performance gap will lead this discussion.

Donald Casey: Well, as the lead for this measure, I would – I would posit that the original intent of this measure and the others in the set was specifically around the actual lack of data. And I believe that over time, that the generation of this information has – has shown a performance gap that is some variation in terms of how – how this performs across providers and populations.

So, my – my gestalt – and, Jeremy, you could – you could chime in here as the secondary viewer – is that this is – this has actually demonstrated variation and – and was developed based upon an expectation that there would be.

Jeremy Boal: I agree, Don.

Donald Casey: Any other questions or comments?

(Jill), do you have any – anything to add?

(Jill Slinger): I think that there – there has been documented variation and opportunity for improvement that has been acted upon by the hospitals that have participated. About 50 previous – prior to the state of Minnesota's 79, and the current project, which has about 120.

But there have been sub-optimals. I – I think that – when I came on, you were talking about some other measure that was possibly going away. I think that as (DHR) comes up, and the meaningful use criteria – which I've included in an appendix, I think – I think that this measure – these measures, too, can – can go away as we standardize the electronic transmission of information.

Donald Casey: Right. But this is as is now. And you did capture that very nicely in your memo, that we did review.

(Jill Slinger): Well, thank you.

Dana Alexander: Hello, this is Dana Alexander.

Donald Casey: Yes.

Dana Alexander: I just would make the comment – although I do believe as we – as there – becomes electronic data to capture – or electronic systems to capture this data and transmit, I think the intent of these measures will still remain very much needed. It will just occur in a different – occur in a different way and a different probably time sequence.

(James Leahm): I think that these measures are important, as we look at EHR as a way to be more transparent and be more accountable for care, and even down to the patient and family and consumer level. And so, currently, it seems like it's adequate in terms of providers or institution infusion, transfer information. You know, thinking more broadly, people with online access to health records, for example, some accountability might still be a good thing.

(Jennifer Leo): Hello, this is Jennifer Leo. It strikes me that with this measure having been endorsed, it would be very important to demonstrate that it was working at a high reliability before we even considered its discontinued endorsement. So, even though we may have electronic records, we all know that electronic records are only dependent upon what is put in and is able to be retrieved.

So, I think that you – you'd have to say that the reliability of the use of these measures, and including (bridges) by directionality of receipt and action upon the measures would have to be documented before you took it out.

Donald Casey: Yes, so let me – let me help – I mean, these are good – good discussion points. Let's – let's focus our thinking around the questions around clarifying if there's any additional uncertainty about the performance gap on this slide that is showing here so that we can stay focused on this.

We will have other opportunities to add in the – and your comments are relevant, but let's really focus on this one (piece). And certainly, the technical aspects of this play into it, but let's use what's in front of us right now to – to move through this.

Brenda Leath: Certainly the measures, in my mind – excuse me – address issues of consistent movement of information between the (inaudible) care. And we know that the absence of that puts – leads to gaps in having information in a timely fashion to address the needs of the patient when they have moved to a different facility.

So, I do think that this – these measures – this measure addresses a performance gap, and has the potential for reducing some of the errors that might be occurring. But again, documentation of that would be necessary to – to assess that.

Donald Casey: OK. Why don't we go ahead then and vote on this one – on this performance gap question here? Under "important measure report." So, get your …

Female: So, (Poonam's) going to …

Donald Casey: … your computers ready.

Female: (Poonam's) going to guide us?

Poonam Bal: OK. Voting for performance gap is open.

OK. Voting for performance gap is open.

OK. Last call for voting.

OK. The final results are two high, 15 moderate, 0 low, 5 insufficient. Thank you.

(Crosstalk)

Female: I just realized my vote didn't go in on the ones prior to this, being how it popped up on this one, but I can circle back.

Poonam Bal: Do you feel verbally doing? Or, you can also send us a chat if you'd like. We can document the vote.

Female: Perfect. Thank you, sorry.

Male: But it looks like we – we can move on to the next.

Female: Yes, we can move on.

Male: So, now we're – now we're going to vote on whether or if this is a high priority relative to the national goal, and relate it to a high-impact aspect of health care, and the issues in parenthesis are examples of it. But – so this seems pretty straightforward to me. Any questions about what you're voting on?

All right. Why don't we get our voter ready now?

Poonam Bal: OK. Voting is now open.

Male: Poonam, one thing we might want to do is just look at the grand total and see if that matches with the number on the call.

Poonam Bal: Yes, of course.

Male: So, we have 22.

Poonam Bal: We're looking for one more.

Male: Maybe Barb – Barbara would vote again.

Barbara Gage: Nope, mine went in this time.

(Jill Slinger): This is (Jill). I'm not voting, I'm assuming.

Male: Right.

Female: No (Jill), you shouldn't be able to vote.

Male: (Jill) shouldn't.

(Jill Slinger): It is actually showing up on mine so that I could be voting, but I'm not.

Poonam Bal: So, we do have 23 now. So, the final score is eight high, 11 moderate, four low, zero insufficient, meaning we'll go on to the next criterion.

Male: Great, Poonam.

OK, now we're into the scientific acceptability of measured properties, and this is in the context of us voting first on the exception and next on the other two importance criteria, moving – moving into the discussion of the scientific acceptability. This is reliability is outlined in the measure specifications and report that was delivered to you, and the testing. So, any questions for the committee about this criterion?

Want to move ahead, Poonam?

Poonam, do you want to get ready to vote?

Female: So, Don, did we want to have any additional discussion about the reliability from either yourself or the co-discussant or the work group or steering committee members?

Donald Casey: I don't have anything to add. Jeremy, do you? We did discuss it up front.

Jeremy Boal: Yes, no. I think you covered it, Don, in your summary at the beginning. We can repeat that if people want us to go back to it.

Donald Casey: Any questions?

Emma Kopleff: Again, it might be helpful to bring up the algorithm or have folks look at the algorithm. I would take some comfort in knowing we're all making the decision based on the same criteria as listed in the algorithm.

Donald Casey: Sounds good.

Emma Kopleff: For instance, I'm not sure we discussed sort of in-detail, the testing results, which were not presented at the data element level, but were presented at the facility level and not sure how that (Crosstalk).

Female: So we have a comment?

Donald Casey: Emma, I think, was – was asking to have the criteria put back up.

Female: OK. We're putting that on the screen. And it's up on the screen now, and you know, we began with of course with the precision of the specifications. If there's some discussion about the precision there. And then we would move to box two regarding the testing and the level at which the testing occurred. And for those who might not be able to read it, the question in box two, which was, empirical reliability testing conducting is a (simple) test with the measure as specified.

So, if you would move to box four, which was reliability testing conducted with computed (performance) measures for each entity.

Male: OK. So any questions about this? You have the – you have the document. We presented the summary of it. Any questions?

Emma Kopleff: This is Emma again. I guess my statement with the follow-up question would be where this led me was from box two, I landed at box three, which was that the answer was no, due to the results provided, which led me to rating it as insufficient, and I'm open to – I would really like their feedback if others use the algorithms differently, so I can understand how we as a committee are voting.

Male: So, I think the – it was clear from the – from the report that (inaudible) levels of data was not provided, and that this was (Jill), as I recall, at the hospital level, right?

(Jill Slinger): Yes. The – the reliability was at the hospital and at the reviewer's level, at the individual reviewer's level.

Male: Right. The – the reviewers were evaluated in terms of their – their concordance.

(Jill Slinger): Yes.

Male: OK. So, Emma does that help?

Emma Kopleff: Yes. Maybe it's a question – maybe the question is really to be addressed after people vote. I just feel that with the importance criteria, we went through the sub-criteria, I didn't have a good understanding of why people voted the way they did, and I know we don't have time to go through that for every criteria, and I'm sure we'll get in a groove as we keep moving here.

Donald Casey: Right. And there's variation in terms of how people view these criteria. These are not – you know, these are not etched in stone, and you have to have some flexibility in terms of understanding how to apply them. And we do our best, and this is – this is what the process is.

So, Poonam's got the reliability up here.

Poonam Bal: OK, are we ready to vote?

Donald Casey: I think we are.

Poonam Bal: OK. Voting is now open for reliability.

OK, we are at 23 now, so the final results are zero high, 11 moderate – got one more. OK. Last call before we call the results?

James Lee: Hi, this is James Lee. I'm sorry, I'm having some computer issues. I'd like to vote moderate, please.

Poonam Bal: Thank you.

Donald Casey: Thanks James.

Poonam Bal: So then, we have zero high, 12 moderate, (inaudible) for insufficient, meaning we will move forward with the measure.

Female: And Poonam, I believe James' vote did count. Looks like he did register on the voting.

(Crosstalk)

Female: Eleven moderate, 12 low.

Poonam Bal: My mistake. So can we …

Female: Can we revote quickly, to make sure that we've recorded everyone's vote correctly on the reliability?

Poonam Bal: We can't refresh it, but if everyone can just revote, that would be great. It does only count one as long as you're voting on the screen.

James Lee: Yes, this is James Lee. I've just voted online, so.

Male: OK great.

Poonam Bal: OK, so we'll just give everybody a couple of seconds to go ahead and you know, think this through again, and then we'll vote, and we'll determine how to move forward.

Male: Looks like we've got them now.

(Crosstalk)

Poonam Bal: So we have, you know, a total of 12 moderate and 12 low or insufficient, which actually puts this measure, this voting on this component in the gray zone? And that we continue – and in which case we do continue to vote. But technically, we haven't really reached consensus on this particular piece.

Beth Ann Swan: Hi, this Anne Swan. I thought there were only 23 people voting. Have we – and that adds up to 24.

Female: (Shawn), has someone entered the call?

(Shawn): I'm double-checking the count right now.

(R. Colby Birch): But actually, this is the – when I voted. when we put the revote up there – this is (Colby), when we put the revote up there, I did revote again. And then my checkmark disappeared on my screen and I remarked it as (inaudible). So I just want to make sure that mine was only counted once?

Female: OK, that eight has now changed to seven that was on the screen. So –

Male: I have 23 voting.

Male: OK, OK.

(Shawn): Yes, we are in, fact 23. And the count is correct. It does appear as though it took a minute to readjust the vote.

Male: So that doesn't change the situation in terms of …

Female: No.

Male: Where this is heading, right? So …

Female: Correct. That's correct. So we are still in a gray zone for this vote. So we're able to move on to our validity vote.

Male: Well, let's do it, just because I think it's important to get through it. and we'll see from there. So here again, we're talking about the specifications consistent with evidence, testing, the risk adjustment, comparability, multiple specifications and the missing data. And again, without getting into all the micro details of this, there was careful attention to the extent posited by the measures first to address the validity issues and these are also field tested

quite extensively. So there are challenges. These were not risk adjusted, as I recall, (Jill).

(Jill Slinger): That's correct.

Emma Kopleff: And the missing data was also somewhat of challenge, although I think they did take steps to handle that. So – and so, I think – this is Emma Kopleff. I mentioned this on our preliminary call, but I'll mention it again because from the lens of my organization has been extensively involved in patient engagement work. For future measurement work, it would be really great to engage patients as part of the expert panel engaged in assessing importance around the focus of different measure groups, and (inaudible).

Female: I think that's an excellent suggestion and we will incorporate it the next time. (Inaudible) partnerships.

Male: Any other questions or comments of the validity issue here? (Inaudible), are you ready to go?

Female: OK, so voting for validity is open now. And just so you know, I will be setting one-minute timer, as it standard for our procedures. So at that point, if we have enough (inaudible).

Male: Looks like we need one more.

Female: Yes, we just need a – OK, we have the number, thank you. so the final results are zero-high, 16 moderate, 4 low, insufficient 4, so we do move forward.

Female: OK, that moves us to the discussions and vote about feasibility. Any additional discussions? So is there any other discussion about feasibility before we move to a vote? Don, do you think we're ready to vote?

Donald Casey: Yes, I think so. I think we've (inaudible).

Female: OK.

Donald Casey: I think that measure development did a good job (inaudible).

Female: OK. Voting for feasibility is now open. OK, we're at 22. One more. OK, last call. OK. Then the final results are 10 high, 10 moderate, 2 low, and zero insufficient. And we move forward.

Male: OK. Usability and use. And I think this is the last one, right?

Female: Yes.

Male: So here, again, is the – how the system used vis-à-vis public (inaudible) and whether the use of it is an result and improvement and the benefits are (inaudible) patients and populations. So again, we have the information before you and (Jewel) said that there's going to be additional valuation of these questions. So, you – any residual questions about this? All right, (Gwen), do you want to set us up?

Female: Sure – so the voting for use and usability is now open. OK, we're at 22 again. Last call for the last person. OK, the final result will be 7 high, 12 moderate, zero low, 3 insufficient meaning we'll move forward to the final vote.

Male: OK, so now we're using everything we've done (inaudible) to address the question, if this measure meets NQF criteria for endorsement. And remember we're not endorsing the measure, we're answering the question does it meet the criteria. And the endorsement is done by the NQF members. so – and also evaluate it by CSAC and the board. So there are other steps involved here.

Female: So are we ready to vote?

Terry O'Malley: Hi, this is Terry. Just a clarification. So this is our opinion about whether criteria, not whether we want to make any additional comments to essentially move.

Male: Well, we'll have the ability to continue to make comments, Terry. But right now, I think what we want to do is add everything up and then ask each member to vote his or her opinion on those questions.

Female: And there will also be – yes, and we can also, if there are comments that you want to make, either now or after the vote, we will also, you know, record those for inclusion in our report.

(Dawn Hall): And this is (Dawn). I just want to clarify again this is how it's written today, not with any expansion.

Female: That's correct.

(Dawn Hall): As it stands today.

Male: That's right. That would be – that's applicable to all the measures for the voting.

Female: OK, for the (inaudible), OK.

Male: OK. So shall we?

Female: Certainly. Voting for recommendation for endorsement is now open. OK, once again, we're at 22. Maybe we lost the 23rd person. I'm not sure. Last chance?

(Sara): Hi, this is Sara. There's only 22 now. Shari Erickson had to get off the call.

Female: OK. Thank you.

Male: OK, thank you.

(Sara): You're welcome.

Female: So then the final results are 16 yes, 6 no. So this measure will be recommended for endorsements.

Male: So this is excellent work. And you know I think what we have to do is obviously move on here because we have a little less than an hour left on this. And I think this process was important for a number of reasons, because it sort of got our feet wet and it also shows that this process does work, in spite of imperfections. And I think the committee did a great job. So …

Male: May I interject? Is there a chance for a brief break?

Male: Pardon?

Male: May we take a break?

Female: Given the interest of time, we're going to just kind of move forward. The call is expected to end at 5 p.m. So given the interest of time, we want to kind of just walk through it.

Male: I would say, unfortunately, as far as bioplates and things, I think we're going to have to rely upon moving ahead here. So I apologize for that, but we really do have to keep moving because we've got three hours tomorrow, too. So that's one of the challenges of not having an in-person meeting.

Male: In person, we would be having a more reasonable schedule.

Male: Well, I understand, right. So, let me ask Angela, should we keep moving with the U of M measures, Angela?

Angela Franklin: Yes, we should keep moving. And I apologize for the compact nature of the call. And in addition, as you're reviewing the measures there are several, and Don, I'm sure you're going to point this out, there are several issues that we really dug into. And the first measure that may also be applicable to these following measures. So, where we can avoid repeating information that we've already established about the first measures, that would be great.

Donald Casey: Absolutely. Right. So …

Angela Franklin: And then …

Donald Casey: … Yes?

Angela Franklin: Oh, sorry.

And also, a refocus, because this is fall, we want to be clear about the pieces of the measure and the criteria that we're discussing for the measure, so we want to keep that nice and crisp when we're going through our discussion.

Donald Casey: So …

(Richard Antonelli): Don? Don …

Donald Casey: Yes?

(Richard Antonelli): … this is a point of – oh, I'm sorry – this is Rich Antonelli. I'm – I am keen to know how the – the point that we put in – the parking lot – will be synthesized for review by the committee. Will the staff take that offline and share it via minutes? Will be able so see some of these conditions tomorrow to think about them? Or what – what …

Donald Casey: Yes, yes. I think the staff will – will consolidate these, Rich, as we said. There will be additional discussion after we're done voting. And we can reflect on these. And we – these will also end up, in many ways, lateralizing over the gap – the gap the committee – it's going to identify the gaps.

And I also think it's valuable to have the measure developer on here for feedback. So, the answer is, as many ways as we can, we're going to capture …

(Richard Antonelli): Perfect. Thank you.

Donald Casey: Yes. Sure. Sure.

So, with that in mind, Gerri, do you want to – do you want to go to 292?

(Gerri Lam): Sure.

OK. So, 292 is second in this set of measures. And it looks at the transfer of vital signs between the health care facility and the receiving facility. The vital signs are pulse, respiratory – respiratory rate, blood pressure, oxygen stat, temperature, and (Glasgow), when appropriate.

Don, do you want me to just give an overview like you did? Quick?

I will just kind of hit the high spots. I think the issues in this one are very similar to the ones we've been discussing. This measure, like the others, is filling a gap. It's expected to be short-term. I'm not going to go through all the detail.

We have the same issues on evidence that we have talked about before. It's based on lit review and expert panel. There's not much detail on a systematic lit review. There's no grading of the evidence. And does not deal with gaps in care, although there are emerging data on transfers being more problematic. And information on disparities is not provided.

Same issues on reliability and validity that we have talked about, and also, the same on feasibility and usability.

So, I think the difference here is the actual content of this data, which is the vital signs. And that's pretty much it.

I think (Dawn) is the secondary.

(Dawn), do you want to add stuff?

(Dawn Hall): No. This is (Dawn). I think you summarized. I'm going through my notes. I can't think of anything else to add.

It's just – it's – we're missing evidence of the outcome on – on this, so I concur with what you've presented.

Donald Casey: Any – any questions or comments from the committee?

Lorna Lynn: This is Lorna Lynn. Just a quick question. When they say "entire vitals signs record," does that mean every vital sign taken during the entire time, or that complete set at the time of discharge?

Donald Casey: Let me ask (Jill).

(Jill Slinger): Yes, this is (Jill). That would be – we – we need to have one set sent, but often, they send the whole spreadsheet that – that they've been taking the vital signs on. So …

Lorna Lynn: Oh.

(Jill Slinger): But the criteria is for at least one of each of those three sets.

Lorna Lynn: OK, thank you.

Donald Casey: Other questions?

OK.

And I think, to Angela's point, a lot of what we discussed before applies here. So without further ado, Poonam, do we want to get ready here?

Poonam Bal: Yes, of course.

So, we're ready. The evidence pool is not open.

Donald Casey: 22.

Poonam Bal: OK, perfect.

Donald Casey: So, it sounds like we're heading down the same pathway.

Poonam Bal: OK, so we have zero high, zero moderate, one low, 19 insufficient with exception, and three insufficient. So, we do move forward.

Donald Casey: OK.

Any questions before we – we vote?

All right, Poonam.

Poonam Bal: OK, voting for performance gaps is now open.

OK, we are at 22. All right. So, the last – oh. Wait.

All right, last chance.

OK, so we have zero high, 13 moderate, five low, four insufficient. We do move forward.

Female: And this is …

Donald Casey: OK.

Angela Franklin: So, this is another area – this is Angela – where it looks like there is a quiet consensus on this – a (vast) area – and we'll move forward with this. This is a gray area piece. That's 11 – that's 13. Oh, this is 13 and five.

Donald Casey: Angela, just remind of the process. We used to record the vote counts. Now we just make a qualitative statement when we put this into the report for the vote?

Angela Franklin: No, we will be recording the actual votes, but there's a percentage in terms of – that we do now to show whether a consensus was reached. That will be included in the report and discussed as an area where there was some – a bit of lack of – lack of consensus.

And …

Donald Casey: OK.

Angela Franklin: So, that moves us to 1C, high prices.

Donald Casey: Yes.

Priority – Gerri or Dawn, if you want …

(Gerri Lam): No, I think we – we are dealing with the same issues we dealt with before in terms of it, you know, indicating that communication of this information is, in fact, important. However, the data are lacking.

Donald Casey: OK.

(Jill Slinger): This is – this is (Jill). I think that the way we address it was that it was one of the national patient safety goals, and that we discussed the number of patients that were transferred. And you're right – we don't have information on specific consequences.

Angela Franklin: Are there any other comments, or are we ready to vote?

Donald Casey: I think we're ready.

Angela Franklin: Voting is now open for (price).

Donald Casey: 22.

Poonam Bal: OK. Last-minute change your vote before I make the final announcement?

OK, we have six high, 11 moderate, four low, one insufficient, meaning we move forward on to reliability.

Donald Casey: OK.

Any other comments here, (Gerri)?

(Gerri Lam): Just to repeat, inter-rater reliability was shared. It's simple agreement. It's not corrected. It is not as specific to the data elements. And I guess it was the same we talked about last time.

Donald Casey: Yes.

OK.

Let's go.

Poonam Bal: OK. Voting for reliability is now open.

Donald Casey: Looks like it.

Poonam Bal: OK. Last chance to change your vote.

OK, we have zero high, 15 moderates, four low, three insufficient, and we do move forward.

Donald Casey: OK.

Validity as is. This is comparable to the first measure, Gerri, as I recall.

(Gerri Lam): That's correct. Face validity is provided based on an expert panel. There is no risk adjustment or stratification.

Donald Casey: Shall we?

Poonam Bal: OK, perfect. The voting is now open for (billing).

OK. Last chance.

Female: I'm not getting the – it hasn't popped open on (inaudible). It hasn't popped open on my screen.

Male: Do you want – who's talking? Barbara, do you want to just tell us verbally?

Barbara Gage: Sure. (Inaudible).

Male: OK. Thanks.

Female: So then zero, high; 13, moderate; 7, low; 2 insufficient. And we do move forward to feasibility.

Operator: And Barbara, if the vote fails to appear on your screen, you can refresh your session by refreshing your browser line or pressing F5 on your keyboard.

Male: Thank you.

Female: Thank you.

Male: Feasibility?

Female: Just a reminder, there are multiple sources of data. It depends on different data sets. The measure developer said that there has not been a problem in the past.

Emma Kopleff: For the good of the order, this is Emma Kopleff and some of our background comments, assuming other committee members agree, I would say that it doesn't surprise me that the feasibility is rated quite high for (inaudible). I thought the developer did a good job of demonstrating that, but that's part of what concerns me about the measure in terms of (inaudible) that as standard practice of care around the transfer of basic information, as opposed to quality data.

Male: Great. So as presented, let's vote on this one.

Female: OK. Voting feasibility is now open.

Male: Twenty-two. Yay.

Female: OK. Last call, if you want to change your (inaudible).

OK. We have 12, high; 9, moderate; 1, low; 0, insufficient; and we do move forward to (inaudible).

Male: OK. Questions? Comments?

OK. (Gerri), do you want to (inaudible)?

(Gerri Lam): I think again, usability looks at the likelihood that this measure will enhance quality. And this measure has been used in a variety of other projects and the data are – are beginning to come in in this area.

Male: OK.

Showtime.

Female: OK. Voting is now open for usability.

Male: One more.

Female: OK. I'll just give one last call.

OK.

Male: Did anyone not get to vote? I got …

Operator: We do have a member that has stepped away for a few minutes. They did indicate that.

Male: OK. All right. Well, this one probably doesn't look like it would be influenced by one more vote.

Female: No, it would not. So the final results are 4, high; 12, moderate; 3, low; 2, insufficient; and we would move forward to the final decision recommendations.

Male: OK. So I think you understand this one now. And vis-à-vis Terry's point, any last – does anyone want to make any last comments before we go?

Female: I would just like to emphasize what I think (Rich) has been – been sharing, as well as Terry, which is I think it's critical that our comments get reported. My concern being is that we are overriding based on basically (face) validity and this being foundational. And I take the earlier comment very seriously about what the message is and the signal we are giving in overriding.

Male: Right.

Female: But these aren't (projected) measures. These are basic measures collected during treatment practices. So, they're not really controversial, no?

(Richard Antonelli): This is (Rich Antonelli). I'll respond to that. I think it's not so much the issue of controversy as that this is basically transmitting information. If you will, it's communication. And we are trying to leverage that framework of care coordination to say that communication is foundational and essential, but coordination takes it to another level.

So that – that's the issue here about it. It's not controversy. It's we don't – we don't want to send the signal to the care coordination community, and in

particular the patients and families that are relying on us to close the quality chasm. Endorsing measures that are in the communications domain, don't go beyond that is what we're struggling with.

Male: So, (Rich), if I can try to (inaudible). I think you're – and we've been through this many times, pointing out that just because communications occurred doesn't mean necessarily that care coordination has occurred. But, you know, on the other hand, we don't – we don't use (semaphore) smoke signals or other more primitive ways to connect. So this is what we have – today and it's evolving. So, yes.

(Becky Answan): This is (Becky Answan). I would just like to tag onto that last comment relative to the vital signs of some of these other measures. Just because you transmitted one set of vital signs, why is that care or care coordination (inaudible).

Male: Well, that's – that's a fundamental question. And I think what we're trying to say is that it isn't – it isn't by itself care coordination, but it is a necessary component of it. And you could argue the point about whether it should be one vital sign or whether it should be a whole host of them, but I think that's – that's kind of the state of nature that we have to think about here when we vote on this.

Ellen Schultz: This is Ellen Schultz from Stanford. And you know, I would just say that I think what I'm hearing here is some of the tension of being asked to vote on individual measures as they stand, while at the same time we're all keeping in our mind a big picture about the future of care coordination, trying to be aspirational in driving the field forward; and also thinking about a portfolio of care coordination measures.

You know, if we were voting on a portfolio and ranking measures, we might be having a little different discussion. And I think many of us are thinking along those lines, well, how important is this versus some others. But that's not actually the task that's before us. So I think that's some of the challenge thinking about this.

And while I totally agree with the comments that, you know, this is maybe a minimum level of communication is necessary, but not sufficient for care coordination. I – I'm hesitant to take away a tool that would at least start to measure part of the care coordination processes because there actually are so few of those out there. And we're really, like, at step one when it comes to care coordination in our health care system.

So, I think it's appropriate that we have some measures that start with baby steps. It's such a comprehensive concept that I don't expect there's any one measure that would get at every aspect of it. So if we set the bar that high, we may end up with nothing, and then we really do a disservice. So that's my own thought process.

Male: Thank you, Ellen.

Jeremy Boal: This is Jeremy Boal. I just want to second that. I have nothing more to add. I think you captured it perfectly.

(R. Colby Birch): This is (Colby). I agree. I just – I guess at this point, I – I probably need a guiding question that we should be answering in our voting. Is this in the context of care coordination, that it also enhances quality? And then answer the questions that were presented algorithmically, that is it feasible – all of the (inaudible).

Can someone clarify that for me at this point?

Male: Yes, so (Colby), this is an excellent question. I think for the purposes of protocol, as I'll call it – forgive me – we should be putting front and center the questions that are – that are posed through the voting of the criteria. But in the back of your mind, you've got to add in this coloring, but it doesn't per se – one doesn't trump the other in this case because these are, you know, these have rough edges around them and they – they sometimes, for lack of a better word, bleed into other areas.

So I would say it's important for this group to pay attention to that larger question, but most importantly at this point, given our work, get through the criteria or, you know, granularly around the intent of the criteria.

Does that (inaudible) (vagary) help you at all?

Male: It does. I'm just hearing – this is my first – this is my launch into work with the NQF. And I've been interested to listen to everyone's questions, and people have brought up some very substantial concerns related to how we vote and actually what we're addressing. Is it the primitive stage of – stages of care coordination and it's fit in that? Or, you know, and then the (sundry) other perspectives.

So, I'm just trying to really do this justice and try to figure out what exactly I should be targeting when I'm voting. Is it just the strict measurements – the measure criteria for in the guidance? Or like you said, do we overlay or at least underlay some of the other considerations like care coordination and the benefit to quality and quality of treatment over time?

Male: My answer is yes, yes and yes. And, you know, having been on other measure committees like many of you others, especially when we get into some of the specific areas where there are, for example, outcome measures of, for example, mortality, and there are much more structured ways to evaluate evidence in what I'd call more of a closed system, it becomes easier to apply these criteria. So, you know, to some extent, we're using a method that works better in some areas of discussion than it does others, vis-à-vis its feeling of precision.

I think that's what we're all struggling with here, knowing that in our hearts this is big problem that we've got to get at, so.

Male: If I could just ask one more question, when we talk about usability, and these pieces, since care coordination's definition, we've defined it, and we've bought into it. But, at the same time, some people, as a nurse, I could not say goodbye to vital signs as an – as an essential part of the communication package that comes with a patient.

Nonetheless, some people who are not clinicians provide care coordination services.

I mean, should we consider this in a clinical setting?

I know this is in a rural hospital scenario and certain ones are in rural hospital scenarios and all of that.

Should we be looking, again, at the bigger picture here? You know, if it's a lay person or a social worker, that may not be clinically focused for that person at that time, it may not be essential; it may not be usable.

How do we address that? That's just been milling round in my head for awhile here.

Male: Yes, so I think Emma was trying to get at that a little it more in the – in terms of the futuristic look as to how we might reconsider approaching a measurement paradigm that we're upon, And I think that's good feedback.

But for the purpose today, capturing that spirit is important, but voting on what's in front of you right now is really what we've got to stay focused on.

Male: I hear that. OK. I appreciate it. Thank you. Thank you. Appreciate it.

Angela Franklin: And this is Angela. If other members, if you have comments and questions along these line, that we're going to have a (rich) discussion, hopefully tomorrow, about this, in light of the measure prioritization process it's undergoing.

So, if that's helpful, that discussion then would be very valuable.

Male: Yup.

So, why don't we try to put this baby to bed here, with our final vote, knowing that there's still plenty of time to capture other comments like (inaudible)?

Female: OK. Perfect. Voting is now open for (inaudible).

Marcia Guida James: This is Marcia. I am on. I had to go mobile, so can I give my vote verbally, or at least e-mail it in later? How would you prefer?

Male: Marcia, why don't you e-mail it in. We – it turns out that the part that you missed, it – I hate to say it, wouldn't have made much difference in terms of the outcome, and I think it passed.

But we certainly would punch your vote to count. So, by all means, if you want to e-mail Poonam and the team on that, that would be fine.

Marcia Guida James: OK, that's fine.

Female: (Inaudible) verbally saying it, that would be fine as well. Whatever you feel comfortable with.

Marcia Guida James: OK. OK, I'll – you know, on this one, I'm moderate, so.

Male: OK. Good.

So we have 20 now.

Female: All right. OK.

Last call for any additional votes.

OK. There we go.

All right, so we're going to have – the final results are 16 yes, five no, and this measure will be recommended for endorsement moving forward.

Male: That sounds good.

And thanks to everyone for hard work.

It's – I have on my clock between 25 and 20 minutes to go here. So why don't we try to push forward on this one, knowing that if we're all back tomorrow, and we pick up where we left off, we can probably – Angela, you've pretty well, knowing that there'll be room for discussion, but why don't we, in the interest of time, move to 293.

And I'm going to ask Pam and Emma to take the lead on this.

Pamela Foster: OK. This is done. And this is Pam.

I really have nothing to add. I think Don and Jerry did an excellent job of giving the overlay of the measures. This is another measure that is potentially a transfer of information. So I have no additional information, other than to tell you want the measure consists of, which has to do with medications.

And this one is measuring whether the transfer of information regarding the medications went with the patient, and that would include medications from home, allergies, and then any medications given prior to transfer, so that information must accompany the patient.

Male: Pam.

Emma, do you want to add?

Emma Kopleff: I would just clarify that the measure doesn't, again, similar to the other ones, it doesn't make – sort of mandate, I suppose, that the information follow the patient. It's just the information being sent, the same as the other measures.

And I think as far as the arguments around lack of importance has already been stated today.

Male: Other comments on this one?

Richard Antonelli: Tom, this is Rich Antonelli. I remember when we discussed this a month or so ago, we talked about the alignment with the meaningful use.

And I apologize if I missed an e-mail, I think that we had asked the – asked the measure developer to do an exercise aligning this measure with what meaningful use requirements are.

Did that get done and I missed it, or?

(Crosstalk)

Male: It did, Rich. And it was presented by Jill with a – their best crosswalk of these different measures into the meaningful use standards. And I believe – I'm just trying to look here, because I think the memory's a little bit different.

But I do think in the list here, it was item 4, which is current medication list and current allergy list, Rich, that dovetailed with meaningful use.

Female: And, Rich, I can send that over to you again, just so you have the reference.

Richard Antonelli: I'd appreciate that, and I'm sorry that I missed that e-mail. Thank you for doing that.

Male: That's all right. That's all right.

Because, you know, that was the spirit of what was discussed vis-à-vis a lot of this – a lot of this stuff that we're talking about with each of thee measures being overlaid into meaningful use in the future, you know. And we're sort of in the middle of our journey, so it was important.

So thanks for bringing it up, Rich.

Richard Antonelli: Yes, I think the reason I flagged this one in particular is because of the potential for the med reconciliation, which I think is extremely important.

OK.

Emma Kopleff: And, Rich, if I might just ask – this is Emma, and I apologize if this is recent from the last call, but if you and (Guy) can help (inaudible) my memory, because I thought there is an item in meaningful use that overlaps with the medication, the information about the medication list.

Would that be an argument that this measure isn't necessary because the measure is – the information is being captured elsewhere? Did we do a different program's requirements?

Or, in the flip side, I could see Ellen could argue that there is sort of an advantage around alignment, if we were to endorse this measure and put it into some sort of program that aligns with meaningful use.

Male: Yes, Emma, good point.

It was a – it was a conversation around the question of these measures not really being refreshed for quite a while, I think back to 2007. And I think it was really a placeholder discussion about the need going forward for there to be, you know, I'll use the word harmonization, so that makes sense.

But it didn't impact the measure as it was presented by the measure developer It was really just an observation that this obviously needed to, you know, be an expectation for the future. So it wasn't – it wasn't trying to (inaudible) the measure as much as it was trying to highlight the emergence of meaningful use as really sort of embedding a lot of this stuff.

Pamela Foster: Dan, this is Pam Foster again. I just want to say that – and this is kind of getting off here, but the transfer – this idea of the transfer of information that would have to go with the patient, it will be coming up in the next stage of meaningful use here this year. So I think we will see some movement on that.

The other point I wanted to make was that someone mentioned medication reconciliation, and I do want to just clarify that this measure does not include medication reconciliation. It's merely what the patient reports as their medications from home.

And we had a lot of discussion on that in the work group call, but given some kinds of constraints of transfer and the fact that a lot of times these patients are in crisis and they have to get moved quickly, that, you know, the feasibility of doing a medication reconciliation was not really explored

So that is not something that is part of this measure.

Male: That's a great point, Pam. And I think what we said was in the heat of the battle that it's necessarily going to be a real challenge, especially in an emergency setting, to get everything right the first time. But that, you know, we got to do what we got to do.

And I think that was really kind of the spirit of the – of the discussion there.

(Crosstalk)

Male: … from a feasibility standpoint.

Richard Antonelli: This is Rich again.

I'd like to try to dig into that a little, because that – it was both aligned with meaningful use that I was interested in, but also this. So let's sort of move this scenario forward.

So these rules, critical access hospitals are starting to come onboard with M.U. And then they have the expectation of doing this measure, of transmitting med information, which is different than med reconciliation, which they're going to be required to do.

And so, I'm a receiving clinician now, and I've got two different sets of medications. So I'm actually thinking at the level of the receiving provider, and wondering whether I may have just received misinformation, because we're transmitting communications, but it's not coordinated.

So I apologize for stirring the soup, but I am really concerned. This is bigger than harmonization. It's actually potentially transmitting data that's not useful.

Male: Yes, Rich, so you're actually not creating any contrary discussion here. It's excellent because, remember, we are voting on this measure as a measure and not – you know, what preceded this doesn't necessarily mean that we're going to vote the same way here.

And I think what you're trying to say is that this could – having not been addressed since back in 2007, when this was sort of a paper in (Health Affairs), the meaningful use, now it's in reality a day-to-day challenge, you know, on the one hand, just to – to handle the meaningful use criteria, let alone, create an expectation in rural hospitals that you're now going to be potentially trying to serve two masters that might be related, but aren't – they aren't identical twins, so …

Russell Leftwich: This is Russell Leftwich. Relative to meaningful use, three things – one, this is – this measure has a – a timeliness element which is not part of meaningful use, but I think is important.

Number two, meaningful use is a voluntary program, and not all facilities may participate.

And, number three, the requirements for the transition to a care communication of the information would be overlap with this measure. It's only 50 percent of transition to care – which I would not consider a very good score in terms of – of this measure.

Donald Casey: Thanks, Russ.

Other questions? Please.

(R. Colby Birch): This is Colby. Well, I see two sides of the scenario here. In the critical care arena, I can clearly understand the misinformation, absolutely, from the receiver end. But – and, again, there was some breakup on my phone, and I hope that I'm not asking a question that's already been addressed. But what about for all the other scenarios in care coordination, where it is not an emergency situation, where wouldn't we find these reliable? And what do we do if we are dividing our thoughts and saying, "OK, well, it might not be user – not appropriate. But it may not be useful in certain scenarios, but in other ones. How do we deal with that? Or can we not deal with it? Do we have to exclude it because it may provide misinformation – one arena of care coordination? And then another one, like they were discharging to (sub-acute), or something like that – that it would be very useful.

What – can someone help me with that?

Barbara Gage: Are we allowed to make – this is Barbara – are we allowed to make recommendations about a conclusion for a measure? That we would recommend it as good with positional inclusions or exclusions criteria?

Donald Casey: Well, so, Barbara, I think the challenge we're going to face here time wise is that we could drill down into levels of detail here. I think we're looking for a

higher level, at least at this point in our discussions, because we're trying to vote.

We certainly think that if – I don't want to get into the nit-picking of the measure to the extent that we – we get sidetracked from voting. So if it – if you think it's a substantial issue, that's fine. I'm fine with that.

Barbara: Right.

Donald Casey: Use your judgment.

Angela Franklin: Right. And this is Angela. If you were going to make recommendations, you have to understand that the recommendations for changes for the future – future version or iteration of the measure, and not the measure in front of us. And we would be looking at the exclusions issue under the reliability discussion.

Donald Casey: Right.

Barbara: OK. Thanks. And this is definitely not equal to the M.U. measure?

Donald Casey: Right, right.

Barbara: OK.

Donald Casey: I think – I think we've heard that, yes.

OK.

Female: (Inaudible).

Donald Casey: Yes?

Emma Kopleff: Just to – if I may offer a response to the question about the measure being useful in one setting versus another – I would just share, and would welcome others to share if they're not doing the same – but in my mind, as a committee member, I'm viewing the measure as appropriate or not for the facility hospital setting at large. So, even if the evidence is specific to a rural setting, or an

emergency scenario, the measure in front of us is at large for the hospital level.

Donald Casey: Right. And that was Emma, right?

Emma Kopleff: Yes, it was.

Donald Casey: Thanks, Emma.

All right, I'm going to – I'm going to – because we've got about 10 minutes left, I'm going to ask the committee's forbearance today. 'cause I think – I think we should vote. And I think if we need to come back to anything more, we can do that on tomorrow's call. But I do at least want to get this done.

If it turns out that there's – everyone goes to bed tonight and wakes up on the wrong – on a different side of the bed, wants to revisit the vote, we can do that. But I want Angela just to just move it forward so we get …

Angela Franklin: Yes.

Donald Casey: … at least this one done between now and the end of the call, OK?

So, Poonam?

Poonam Bal: Yes. Are you ready to vote?

Donald Casey: Yup.

Poonam Bal: OK. Voting for evidence is now open.

Jeremy Boal: It's Jeremy Boal. I have to sign off. My sincere apologies.

Donald Casey: Thank you, Jeremy.

Barbara Gage: This is Barbara. I fell offline. And I vote for low on that one.

Donald Casey: On – on the – on this one, right? So …

Barbara Gage: Correct.

Donald Casey: … we'll record your vote as a three.

Barbara Gage: Thank you.

Donald Casey: Thank you, Barbara.

(Marsha): This is Marsha. That's the same for me.

Donald Casey: OK. You want to vote three, Marsha?

(Marsha): Correct.

Donald Casey: Three, low. OK, so that adds two more. And that leaves us with 20, Poonam.

Poonam Bal: Yes, you had some people sign off.

Donald Casey: OK.

Poonam Bal: So then with that, we're going to have the final rating being zero high, zero moderate, two low, 15 insufficient with exception, and three insufficient, meaning we will move forward.

Donald Casey: OK. Great. Let's do that.

And I will just respectfully ask Pam and Emma if they – if they want to jump in here on anything specific, please do.

Anything from either of you?

Pamela Foster: OK. I'm Pam. I have nothing to add other than what's been previously stated for performance gaps.

Donald Casey: OK.

Emma Kopleff: I am, thank you.

Donald Casey: Emma, you're good?

Emma Kopleff: Yes, thank you.

Donald Casey: OK. Shall we?

Poonam Bal: OK. Voting is now open for performance gap.

Emma Kopleff: I guess I would – this is Emma – I would just add that the – I don't think this is new information, but to confirm the literature that was reviewed is not specific to this issue around medication. And it is the same literature that was submitted for the other measures.

Donald Casey: Thanks, Emma.

So, with that, just keep that in mind – if you want to change your vote, I'll give you, Poonam, another few seconds here.

Poonam Bal: Yes.

And then, could we also get a verbal vote?

Donald Casey: Yes, those of you that can't – can't click.

Barbara Gage: Thank you this is Barbara. And I will switch on the insufficient vote with the override.

Donald Casey: So, do you – just say the number four, right?

Male: OK.

Poonam Bal: No, actually, that is not an option in gap. It would either be insufficient or it would have to be one of the other ones. We wouldn't – there's no exception for performance gap.

Donald Casey: Yes.

Poonam Bal: So, would you like to (re-hear) that?

Donald Casey: Moderate, low or insufficient.

Barbara Gage: OK. Low then.

Donald Casey: OK. Number three.

Poonam Bal: And then we had one that's a …

(Marsha): And this is – this is Marsha. Insufficient.

Donald Casey: Thanks, Marsha.

And, Poonam?

Poonam Bal: So then we have one high, 11 moderates, five lows, eight sufficient, which would leave us in the gray zone, but we do move forward.

Donald Casey: Yes. This one's been in the gray zone for the – for the other two, too, so …

Poonam Bal: Yes.

Donald Casey: All right. High priority reviewers?

Pamela Foster: And this is Pam. I – nothing to add, other than what's been previously discussed for important measure.

Donald Casey: OK.

All right, Poonam?

Poonam Bal: OK. Voting is now open.

Donald Casey: And while we're voting, if the – if the non-clickers want to just give us their high, moderate, low and sufficient votes verbally, we can have those now.

Barbara Gage: Yes. This is Barbara. I'll say low. This did not include the reconciliation, right? And it wasn't equivalent to the MU.

Donald Casey: Yes.

Barbara Gage: Yes? Then low.

(Marsha): Yes, this is Marsha. I'm going low also.

Donald Casey: OK.

Poonam Bal: OK.

Donald Casey: So, we add two to – to the tree, Poonam.

Poonam Bal: Do we have …

Donald Casey: That gives us 20.

Poonam Bal: Perfect. We have three – oh, people are changing their answer. Hold on. Let's just give everybody a couple more seconds in the system …

Donald Casey: Yes, revote, if you haven't. Just – just go do it again. Just because we're getting some …

Poonam Bal: All right.

Donald Casey: So, we have two more – two more in the low category here.

Poonam Bal: I'm going to give the system a couple of seconds to catch up with us, because I know we run a little slow.

Donald Casey: I think we're – I think we're at – yes.

Poonam Bal: OK.

Donald Casey: Nineteen …

Poonam Bal: Can I give it? OK. So, our final results will be three high, eight moderate, six – I'm sorry – so, eight low, and two insufficient.

Donald Casey: So, we're right at the cut point, Angela.

Angela Franklin: Yes, what – again – yes, this is a gray vote. And – oh, boy. OK. OK. We have …

Donald Casey: We're right on the edge here.

Angela Franklin: Yes, we're right on the edge, I would say.

Poonam Bal: All right, let's read it out again, because I think the system was a little slow …

Angela Franklin: Yes.

Poonam Bal: … catching up, because we did have too many numbers. But now we have three high, eight moderate, eight low, one insufficient.

Donald Casey: So, just 11 …

Poonam Bal: Leave us in the gray zone …

Donald Casey: … 11 and nine.

Poonam Bal: … we would still move forward. Yes.

Donald Casey: OK. So, just – just over the majority.

Angela Franklin: OK.

Donald Casey: OK.

Reliability?

Terrence O'Malley: My apologies. This is Terry. I'm going to be signing off, too.

Donald Casey: All right, Terry. Thank you.

Angela Franklin: So, Don, it seems like we're (Inaudible).

Donald Casey: I'm just wondering if – do you want to stop here and …

Female: Yes, I think maybe save this one to reconvene.

Donald Casey: Yes, because we're right in the middle of it, but we're also getting some more uncertainty in our voting in terms of consensus.

Female: Exactly.

Donald Casey: So I think it might be good if – unless anyone on the committee disagrees to pause here, we may actually – Poonam want to go back to the previous vote, too, as well. And I would ask the reviewers to just put a placeholder of being ready to go.

Female: And we might …

Male: Tomorrow when we meet, if you'd like. Does that sound like a decent plan?

Female: Yes.

Female: Sure.

Female: Just to confirm, you wanted to revote on high priorities?

Male: Yes, let's leave it on high priority, since it is close and up to this point. You know, I think we have enough to move forward, but I think tomorrow when we reconvene, we'll start with this one.

Female: OK.

Donald Casey: Angela, is that OK?

Female: Yes, that would work for us.

Donald Casey: OK. Well, listen, I think we did a lot of work. (Joe), can you come back tomorrow?

(Joe): Yes, I can.

Donald Casey: OK. And then our friends from New York, hopefully, will be in tow. and I apologize if they got on today and had to wait, but we will get to you for sure. And then – so I'll just ask everyone else on the measures set here to be ready and then we have another set that we'll go through as well, and Jerry will moderate tomorrow.

Female: Great.

Male: Great.

Donald Casey: OK, so thank you all. Angela, do you have any final instructions for the committee?

Angela Franklin: No, we'll just reconvene here tomorrow. And if Wunmi has any additional comments?

Wunmi Isijola: No, I think it was a great discussion. Just a note for everyone, just staying in line with the structure of the criteria, I know the first measure took us time. But moving forward to really just stay in line with, you know, some of the topic areas in question. We do, in fact, look forward to hearing from everyone tomorrow and your input. So we will reconvene at 2 p.m. tomorrow.

Angela Franklin: And before …

Female: Just a reminder. I apologize. Just a reminder to all committee members, please use the same link to attend tomorrow that you used today.

Angela Franklin: And before we – before Don, I think we build a public comment piece of this and we have not heard from the public. Should we take a minute here?

Donald Casey: Well, let me – let's do this. Let me ask the operator if we do have anyone on the call that is poised to make public comment from either the membership?

Operator: There's no one else on the call.

Male: There is no one else is on the call, Ann, Wunmi and Angela, is that OK?

Angela Franklin: That's OK.

Wunmi Isijola: That's fine. That's fine.

Donald Casey: So OK.

Angela Franklin: Thank you, Don.

(Jill Slinger): So this is – if I could – this is (Jill), could I make a comment?

Donald Casey: Sure, (Jill).

(Jill Slinger): You know, I appreciate a reminder to people that they focus on the measure at hand, rather than measures that don't exist yet. We know that these measures aren't perfect, but I would have to have, you know, this medication when I was interested to see the lower scores, when there aren't other measures out there that have information being sent. So I appreciate that reminder to them that that's what we don't have, should not be considered better.

Donald Casey: OK. That's duly noted. All right. So thanks to everyone. And we will talk with you tomorrow and we appreciate everyone's hard work.

Male: Bye-bye. Thank you.

Female: Bye-bye.

Male: OK, bye.

Female: Thank you. Bye.

Operator: Thank you. This concludes today's conference.

Donald Casey: Wunmi?

END