NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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2:00 p.m. ET

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

(Shawn): Good afternoon, everyone. Just a reminder for our committee members, your line will be open for the duration of today's call. Please use your mute button when you are not speaking or presenting to reduce background noise. Please make sure your computer speakers are turned down or off and please do not place the call on hold. When live voting questions appear on your screen, committee members only should be clicking in the box next to the answer of their choice so their responses can be recorded.

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

Angela Franklin: Hello everyone. This is Angela Franklin, Senior Director for the project. And welcome to day two of our Care Coordination of Phase III Measure Endorsement Project.

We just wanted to give you a few pointers for today's call. We do have our developers on the call and we ended yesterday in the middle of one measure and we're going to pick up that measure in terms of voting today. And we just want to let everyone know that we'll not be having our discussion of the measure harmonization or the gaps discussion today in the interest of getting through the evaluation of all the measures and with that said we'll be quite –

we have to be quite concise and efficient with going through each of the measures that we have today.

We have to move those two items to a future call. So we will have time to discuss those two items at a future call as well as any parking lot items that were raised both yesterday and today on today's …

And with that, I will turn it over to our two co-chairs, Gerri Lamb and Don Casey.

Gerri Lamb: Great. Thank you, Angela, and welcome everybody and welcome to Day 2. I'm going to facilitate today with Don's (able help). And so let's just go through a little bit of the process today because the goal is to get through the rest of the measures and as Angela was saying we're going to leave some of the harmonization discussion and the gap discussion to another call so that we really have adequate time to talk about it.

So here's the plan for today. And let's – just to recap, we went through several of the University of Minnesota Rural Health Measures yesterday. We're up to 293 which is the medication information. We had, I think really good and important discussion yesterday and I hope everyone feels that they had a chance to voice their comments and to be heard.

Today what we're going to do is we're going to move through the rest of the – those measures. We have 293, 295 through 97 to get through and we're going to try and do it relatively efficiently. Certainly if you have comments, we'll have an opportunity to do that.

Here is the suggested way that we're going to go through it is, we're going to go back to 293 medication information. So Pam and Emma if you could be prepared as primary and secondary on that, we will – I don't think, let me check with Angela and Wunmi probably we don't need (Jill) to do any kind of intro. We'll weight on the measure developers until we get to the new sets of measures, is that correct?

Angela Franklin: That's correct, Gerri, and we do want to be sure if there's questions of course the developer can answer questions about the measure but we will just

continue with the measures. And before we get started we also wanted to just to do a super quick roll call of the members.

Gerri Lamb: OK.

Angela Franklin: So we have record on who's on.

Gerri Lamb: OK. Hang on and let's just finish kind of the plan and then we'll do roll call and then we'll move right in and that will give Poonam some time to get us up in and teed up.

Angela Franklin: Certainly.

Gerri Lamb: So what we're going to do is gets – goes through the rest of the Minnesota Measures and what we're going to ask is that we're going to do it screen by screen so that we can get through each of the vote. And we're going to ask the primary and secondary reviewers of the discussants to do it screen by screen.

So in other words as we go through 293, Pam and Emma, we're going to bring up the important screen and since we've had the general discussions before, if you could focus your comments on any thing relative to the focus of that particular item. So in this case for 293 it's going to be medication information, not the general stuff that we talked about yesterday. And then we'll proceed with primary, secondary, open it up for discussion, any questions to the measure developer and then vote on that aspect then move to the next screen and so on and so forth.

Does anybody have any questions about that process we're going to go through?

Donald Casey: Gerri, this is Don. Hi to everyone and thanks for your patience yesterday. I just wanted to add on that we want to capture the details of future looks of these measures, but I think in conversation yesterday we think it will be best to hone those futuristic comments until we can have another call.

So if you have futuristic comments that you want it discussed, just make a note of them and we'll be able to come back to them. But right now we really want to stick to our meeting and get through the voting.

Gerri Lamb: Thanks, Don. And so please don't lose those comments because those are going to be critical in the scope of our work and certainly in the gap discussion. And so the other thing just to remind everybody, we're going to be moving through this, we won't have breaks, obviously if you need a break, do what you need to, but we're going to keep on moving through. The goal is if we're able to get through all the measures today.

So with that, Angela did you want to do a kind of a check in with everybody?

Female: Yes. Thank you. Yes. So I'm going to go ahead and do the roster and please forgive, I may mess up your names. So Don and Gerri, we already have you, but is Dana Alexander on?

Dana Alexander: Yes. Present.

Female: OK. Richard Antonelli?

Richard Antonelli: Present.

Female: (Colby)? Jeremy?

Jeremy Boal: I'm here.

Female: Juan?

Juan Emilio Carrillo: Present.

Female: Shari? Pamela?

Pamela Foster: I'm here and I will be signing off at 4:00. Thanks.

Female: OK. Thank you.

Shari Erickson: And this is Shari Erickson I think you just said my name, correct?

Female: Yes.

Shari Erickson: OK. I'm on. And I apologize I had to jump off early yesterday but I'll be on all day today.

Female: Great. Perfect. Thank you so much. Barbara?

Barbara Gage: Present.

Female: All right. Dawn?

Dawn Hohl: I'm here.

Female: Marcia?

Marcia James: I'm here.

Female: Jennifer?

Jennifer Lail: Oh, I'm sorry, I'm here.

Female: Charlie?

Charlie Lakin: Charlie is here. I do need to point out one thing and I think it's because I've left the government since our last call. I could not get in to the website. It says my address is invalid. So I don't have access to the webinar pages.

Female: OK. Well, I'll send it to you and we'll make sure you're – you are able to log in.

Charlie Lakin: OK. Thank you.

(Shawn): It's actually OK. I can just actually access his line out and get him in right now.

Gerri Lamb: OK. Great. Thank you, (Shawn).

(Shawn): Thank you. (Cathy)?

(Cathy): OK. One moment.

Female: All right. And then Brenda?

Brenda Leath: Yes I'm here.

Female: James?

James Lee: Good morning.

Female: Good morning.

Female: Hi.

Female: Russell.

Russell Leftwich: I'm present.

Female: Lorna?

Lorna Lynn: I'm here, thank you.

Female: Jean?

Jean Malouin: I am here.

Female: Karen?

Karen Michael: Hi, I'm here.

Female: Terry?

Terrance O'Malley: Hi I'm here. I'm going to need to get off in about an hour and a half unfortunately.

Female: OK. Thank you for letting us know. Ellen?

Ellen Schultz: Yes I'm here.

Female: And Beth?

Beth Ann Swan: I'm here.

Female: Thank you so much.

Gerri Lamb: Are there any other members that signed on that we haven't called?

(Sam Emapher): (Sam Emapher) from Department of Health is here.

Gerri Lamb: Oh, great. Thanks, (Sam).

Female: Oh, great.

Emma Kopleff: Emma Kopleff is here.

Female: Right.

Emma Kopleff: From National Partnership for Women and Families, I apologize if you called me.

Female: Great. Thanks Emma.

Gerri Lamb: One thing – are we good?

Female: Yes.

Gerri Lamb: Great. According to my read here, (Colby) is the only one that's not with us yet?

Female: Correct.

Female: Correct.

Gerri Lamb: OK. Great. Thank you all for being here. Terry, I noticed that you're a secondary discussant, so if time is pressing, give us a heads up so that we can move things around, OK?

Terrance O'Malley: Sure. But I'm actually going to recuse myself from that discussion.

Gerri Lamb: Oh, OK. All righty. That makes it easier, Terry. Thank you. OK.

Terrance O'Malley: No problem.

Gerri Lamb: All right. OK. So Poonam, if you can get us up to the first screen with importance on 293.

Poonam Bal: Yes. It's up.

Gerri Lamb: Excellent. Thank you. All right. So Pam and Emma, we're going to go through screen by screen, are you good?

Pamela Foster: Sure.

Emma Kopleff: Sure.

Gerri Lamb: OK. So what we're going to ask you to do is don't need to repeat all the general information, it's just specific to this measure if there's anything that you need to point out related to the different areas of evidence and so forth.

So 293 med information, Pam, if you would just remind us what the measure is and then move into evidence?

Pamela Foster: OK. Yes. This measure involves the transfer of medication information which includes allergies, the home medications that are reported by the patient and then any medications given at the site and this again is for rural hospitals, transferring patients out.

And I do want to point out yesterday, we didn't mention this but I think it is important to think about in terms of care coordination the transfer information is not just from rural hospital to tertiary hospital, it is also inclusive of skilled nursing facilities and other lower levels of care. And I think it is important to remember that, you know, that's just an important piece, that's an important transfer of information that occurs to multiple settings.

So, we didn't mention that yesterday and I didn't want to bring that up. This measure does not include medication reconciliation so I think that is really a separate discussion for another time. So we are just looking at the measure itself.

In terms of importance to measure, we talked about the other measures that are very similar to this, particularly the vital signs measure that failed to meet the algorithm as established by NQF and I have nothing in additional to add outside of what was discussed yesterday.

Emma, do you have anything else that you would like to throw in there?

Emma Kopleff: I would like to just add a couple comments. Thanks, Pam. One, just to clarify that the point is well-taken about the relevance of a coordinated effort to transfer information across settings, multiple settings, but I would just clarify for those who aren't looking at the specifications or note that this measure like the others in the set, it both specified – it is, excuse me, the measure testing and used today is specific to rural hospitals. And so, the specifications and the testing don't specifically address those various settings of care. But of course, I agree conceptually related to the importance of coordinated effort to relay information to providers across settings.

And related to while we're on the screen about importance, just if I may share where I'm at having had the time to digest a little bit yesterday and think about these measures more fully from the perspective of the – an individual representing consumer organization and looking at the algorithm and the NQF criteria that I, for all the reasons we discussed yesterday, I didn't feel this measure and some of the others but we're talking about this one right now met the importance for criteria and for me I really didn't hear anything or have no comments on a compelling reason why this should be an exception.

Again, coming from the consumer lens, the three elements of this measure, documentation regarding medication history, allergies, and medications given, in my mind as a patient I am sure others of you can relate having been patients particularly around allergies and medication history much of that information lies with the patient.

I understand the importance of documenting it and transferring it. But ultimately I just didn't feel that this measure met the importance criteria or deserved a pass and I'm really struggling with trying to find a compelling

reason to support the passing of these criteria and that it relates to a broader issue around what the value of endorsement would be for this measure.

So I don't want to take us off track I know we have an agenda to get through, but if I may I suppose recuse myself after we get through the importance criteria for this measure, because it really fails badly for me. Thank you.

(Crosstalk)

Gerri Lamb: Thank you, Emma. Thank you.

Dana Alexander: This is Dana Alexander, I would like to make a comment just to something that Emma said regarding the importance and that, you know, medication history and allergies lie with the patient or the consumer, yes, but I can say from experience I've – even from literature review is that it's, you know, there is evidence that very well supports it often that patients don't remember, they don't know their allergies and particularly in an emergent orient – urgent situation where it may not be clear to them that information and why it becomes very important that we're able then to pull that information from the health record and then be able to actually transfer and they transfer and communicate that information in a hand off situation.

Barbara Gage: This is Barbara, I completely concur with the last commenter because think about that patient being sent to the hospital, they are either having a fever or they're having trouble breathing there are all sorts of things going on. You should not rely on them to know whether they're allergic to something that's very basic information going all the way back to the IOM study and Lucian Leape's points about the simple things that could be done to improve care having information on the meds that they're on and when they've last eaten and hot water (is fair).

(Crosstalk)

Gerri Lamb: Can I interrupt for a minute? We do need to adhere and I understand the importance of this, I would just like to hold the group to the evidence discussion and certainly as Don said yesterday, there are a lot of gray zones

here and while we would like to adhere to the evidence, protocol, and the algorithm, there is a lot of nuance as all you are saying we need to move through this.

So I would ask that you focus your comments and speak to evidence at this point if, you know, we will have an opportunity to talk about this in the gaps as well. I think we all so yesterday that there are gray zones in this and the staff will summarize these comments and will bring them back. Remember that this will go through other stages of review.

Barbara Gage: OK. So, this is Barbara, can I propose that the (stewards) go back to some of the early IOM literature and look for the references on the importance of accurate of not having misinformation on medication.

Emma Kopleff: And I know we're moving forward, just one last comment if I may, this is Emma, Barbara, I don't disagree with anything you said, my framing just so people understand where I'm coming from, I think, you know, as was just stated there's some flexibility and some nuance around applying the algorithms and the criteria and I'm of the school of applying them quite probably more rigidly than others and I – so that's how this discussion has been held for understanding that.

The bigger picture I was pointing to is not that there's a lack of evidence, but there's a lack of evidence around why this is an accountability measure rather than a bigger quality issue that quality improvement should address like issues around patient's understanding of medications rather than NQF endorsement which is for accountability purposes.

But moving on, I don't want to hold up the discussion.

Pamela Foster: And Gerri and Emma, this is Pam again, I just want to clarify back to Emma's first point about my comments around the different levels of care, I guess just to clarify what I wanted to point out was that transfers outside of direct acute to acute which include nursing home are included in the numerator for the measure, the numerator would be than any patients you went to another facility the – or, excuse me, with the information and then the denominator

would be all patients who were transferred and I just wanted to point that out because of the issues we all know, one of the main contributing factors for readmissions from nursing home just lack of information being sent and so I think that was just – I just wanted to make sure that that was understood as far as knowing what was in the numerator and the denominator as a measure.

Gerri Lamb: Thank you Pam and thanks Emma for those comments and everybody else who commented on it. I think we should look to the NQF staff to document that we've had this dialogue and I think – I don't recall who said it, but someone said it very articulately yesterday is to reflect the tension f reviewing this in terms of wanting a foundation and yet having these concerns.

So none of that concern will be lost. With that, I'd like to – for us to move into the vote if everyone is ready. Poonam, can you get us to vote up.

Poonam Bal: Ah, yes.

Angela Franklin: Oh, and also in the discussion someone mentioned that they wanted to recuse themselves. And there's no need to recuse yourself, just vote your – vote what you feel about the measure unless you did have a conflict for the measure. So there's no need for recuse.

Female: Angela that was Emma. Thanks for clarifying.

Gerri Lamb: Yes. Thank you for that. OK. So let's go to the vote.

Female: All right, voting is now open for evidence.

I think the system is lagging a little bit so we'll just let it reset because there's way too many votes on (inaudible).

Female: We have a big committee today.

Female: Is it adding to the votes of yesterday?

Poonam Bal: It shouldn't be. (Shawn) could you – give – help us a little bit with procedure, would it be adding on to the votes from yesterday?

(Shawn): Simply because this one was refreshed from yesterday, it may actually be holding votes over since we had actually stopped the meeting and saved it at this point yesterday. So it may actually be holding the votes over.

So Poonam why don't we go ahead. We can – we'll adjust the reporting. I'm going to get us all set here. I'm going to pull leadership from you and we're going to fix this for the voting committee.

Poonam Bal: OK. Sure. But I do remember the numbers beforehand, so we'll just subtract them and give you the numbers. And give me one moment to do that.

(Shawn): OK. If that's what you will prefer to do, not a problem.

Poonam Bal: So the final results are zero high, zero moderate, one low, 14 insufficient evidence with exception and seven insufficient. So we do move forward.

Gerri Lamb: Thanks Poonam. Thanks for pitch hitting to. Let's go on to the next screen. OK. So Pam and Emma performance gap, anything specific to this measure?

Pamela Foster: This is Pam, I have nothing to add outside of the issues that were discussed yesterday.

Gerri Lamb: Emma?

Emma Kopleff: Same on my end, thank you. As of the measures yesterday there's – the evidence supporting variation of care is a little outdated and not specific to this medication issue.

Gerri Lamb: Thank you. Any comments or anything people want to add or discuss? OK. Not hearing any. Poonam can we move on?

Poonam Bal: Yes. Voting is now open for gap.

Gerri Lamb: Looks like you're going to have to do the same thing Poonam.

Poonam Bal: Yes.

Female: That's OK.

Poonam Bal: Well, it's only a couple of sections so we'll just do that for then and thankfully we'll continue on.

Female: Yes. I think it's only like two or three that we need to …

Female: Right.

Poonam Bal: So then if we just pause it on – if everybody this is last chance to vote and then we'll calculate it. All right. If you can refrain from voting while calculate that would be great. Thank you.

OK. The final results are zero high, 14 moderate, five low, four insufficient and that is enough to move forward.

Gerri Lamb: OK. So high priority 1C, Pam.

Pamela Foster: And again I think we covered this yesterday with the other measures. I have nothing to add outside of what was discussed.

Gerri Lamb: Emma?

Emma Kopleff: Same on my end. Thank you.

Gerri Lamb: Comments? Discussion? OK. Moving to voting Poonam.

Poonam Bal: OK. Voting is now open.

OK. We're going to give everybody one last chance to make their selection and then we're going to calculate it. OK. Voting is now closed, please give us a second to calculate the final results.

OK the final results are, high two, moderate 16, low one, insufficient two and we do move forward.

Gerri Lamb: Thank you. OK. Into scientific acceptability, reliability. Pam?

Pamela Foster: Ah, yes, and I don't know that we discuss this yesterday but there – I just wanted to mention that the reliability testing for these measures was based on

an interrater reliability method and I believe, according to my notes, I believe it was – it didn't fail the algorithm but it was more of a moderate.

Gerri Lamb: OK. Is there anything else? Emma?

Emma Kopleff: I also apply the algorithm as we've discussed my – (where it tends) to be a little bit more rigid and because the data elements were not – because the reliability was not tested at the data element level, but only at the facility level. My algorithm led me into an insufficient rating.

Gerri Lamb: Great. Thank you. And thanks for that diversity. That's good. That's very helpful. Any discussion of the comments?

OK, Poonam?

Poonam Bal: OK. Voting is now open. OK. Last call for voting. Perfect (inaudible) for reliability are zero high, 14 moderate, three low, five insufficient and we do move forward.

Gerri Lamb: All right. Validity, Pam.

Pamela Foster: Yes. Nothing further to add other than to note this is base – a base validity testing.

Gerri Lamb: Emma?

Emma Kopleff: I know we already voted on the validity, but just so I could I understand a little bit more, Pam was the moderate rating for the validity was that based on an application of an algorithm that just let you do a different place or was it based on more of a reserving the right to move beyond the algorithm. Just trying to understand where we landed on that last vote.

Pamela Foster: Well, do you mean, we haven't voted on validity yet, we voted on the reliability.

Emma Kopleff: No, I'm talking, yes, I'm sorry if I misspoke.

Pamela Foster: OK. Right.

Emma Kopleff: I'm referring to the reliability.

Pamela Foster: You know what, I don't have the algorithm in front of me at the moment. I just had according to my notes and I know the interrater reliability scores were – I realize that wasn't and again it didn't completely pass and I think if I remember right when I looked at this we did talk about it at the workgroup and I did pass some questions at the time and I can't remember now. I can't recall exactly what questions they were, but I think I was looking more at the scores at the interrater reliability and the diversity of the panel that they used for that.

Emma Kopleff: OK. Thanks. With regards to validity, I rated it insufficient for the following reasons, the expert panel that convened did not include consumer representation and again coming from the ones that I come from with the consumer organization that's very important to any phase validity testing. A second reason was that the systematic assessment of phase validity was not complete as noted or recommended in the algorithm. Third reason was that the testing was targeted to small, rural hospitals only. So that just gets us back to the numerator and denominator while Pam clarified for us that in fact health care facility is the terminology used included by any healthcare facility the testing was done in small rural hospitals.

Pamela Foster: But I – my understanding of, this is Pam are only applied to rural hospital. So the testing wouldn't have been appropriate to do with facilities outside of that.

Emma Kopleff: But were still recommending the measure versatility beyond that.

Angela Franklin: Excuse me this Angela. This sounds like a question for the developer in terms of the testing and the validity testing, is (Jill) on the line? (Jill Plinger).

Emma Kopleff: And Angela I think it may actually be a question for you because …

Angela Franklin: OK.

Emma Kopleff: … whatever level the testing was done in that which hopefully (Jill) can help clarify for us. What I'm trying to clarify is that even if the testing was done at

one level or the other are passing or not passing our assessment of the validity testing and other meets the NQF criteria is based on all facilities because this would be a doorstep of facility level.

(Jill Plinger): This is (Jill), can you hear me? We've not interpretive that if tested the facility for which is intended to be.

Emma Kopleff: I mean, at for instance like NQF quality positioning system where you document all your measures. I've never seen a measure endorsed just for small rural hospital. But perhaps that's a nomenclature that …

(Jill Plinger): That falls within the taxonomy of facility.

Emma Kopleff: OK thank you for noting that.

Ellen Schultz: This is Ellen Schultz. I think Emma (I'm knowing) you're thinking maybe I can state a little different way. That by endorsing this measure we would say it could be used for any facility regardless of whether it's located in a rural area or not. They seem to remember that was in fact the question I asked yesterday when we first started discussing measure 291. If I believe the response I heard was that this would be endorsed for use by any facility even though it was originally developed to serve rural hospitals. And that most of the use to date has been by rural hospitals.

But I agree with you Emma that the validity, you know, ideally would address any facility not just rural ones because that is in fact with the endorsement suggest that it's valid for.

Gerri Lamb: Angela can you confirm that because I recall the same discussion yesterday and we just need to check that.

Angela Franklin: What's – I'm sorry what's the question?

Gerri Lamb: Whether this performance measure would be use for any facility. And so as we look at validity, you know, should we take into account that most of the testing on this for phase validity has been relevant to rural hospital.

Angela Franklin: We typically has not got in that granular in terms of interpreting facility.

Gerri Lamb: OK.

(Jill Plinger): Look this is (Jill) can you here me?

Gerri Lamb: Yes now we can hear you.

(Jill Plinger): OK, good I'm sorry. We – Most of the testing has been done at rural – at the rural hospital level not just Critical Access Hospitals. It can be used at other hospitals but in truth most of the transfers that occur are from smaller hospitals that don't have (likewise) facilities. So this would imply that urban hospitals that don't have certain specialized services. But it clearly wouldn't apply to some of the larger change or to the tertiary university hospitals because it wouldn't happen.

Gerri Lamb: Thanks for the clarification (Jill). Any other commends on facilities as we move forward and thank you all for the comments and your thoughtful review of the algorithm. It's really good to have that continuum represented in our discussion. If there are no more comments, go ahead.

Terrance O'Malley: This Terry O'Malley. Just a general comment there's a lot of validity work that's been done in transitions to other sites of care particularly hospital, the nursing home and post acute care that's not sided in the references that we got to look at. But to the extent that it bears validity they are probably, you know, 20 expert consensus groups that came up with basically the same data elements. I think there's so much broader area of support from the validity.

Gerri Lamb: Thanks Terry that's really helpful. Any other comments on this? OK, Poonam.

Poonam Bal: OK. Voting is no open.

Emma Kopleff: This is Emma as we move, may I just ask a question that won't affect the voting and maybe it's for another time. I was just curious while we have the developer on the phone around the rationale for excluding home hospice patients from the measure and again we can take that offline if the Chair feel like that's not the discussion to be having now.

Gerri Lamb: You know, I think Emma you're raising great points, if you're OK with us noting that and we will come back to it and perhaps in the follow up gaps discussion we can do that really we'd prefer not to affect of voting with more input from the developer at this point.

Emma Kopleff: Sure.

Poonam Bal: So we only have 18 votes right now. If there's anyone who hasn't had a chance to vote, please don't – do so now.

Charlie Lakin: This Charlie. As far as I know I'm not (inaudible), I'll find a way in. So I will vote later or just abstain whatever works best for the process.

Poonam Bal: If you feel comfortable verbally voting you can do that, but if you do not you can also go ahead and e-mail (inaudible).

Charlie Lakin: If I feel comfortable what?

Poonam Bal: Verbally saying it we can take the vote that way as well.

Charlie Lakin: OK. Just verbally over the phone.

Sheila Crawford: Yes.

Charlie Lakin: OK.

Female: Or you can e-mail.

Charlie Lakin: OK well. Going back, do you want me to go and do that now or why don't I e-mail it to somebody just for …

Female: Yes e-mail it.

Female: And Emma this is …

Gerri Lamb: (This time) Charlie whenever you're comfortable with is good.

Charlie Lakin: OK.

(Jill Plinger): Emma, please feel free that, this is (Jill Plinger) calling – speaking, just feel free that contact me offline I'd be happy to discuss the measures more with you.

Emma Kopleff: Thank you.

Charlie Lakin: OK.

Poonam Bal: OK. So our final vote is (zero) high, 12 moderate, eight low, two insufficient which does leave us in the gray zone but we can move forward.

Gerri Lamb: OK. So Poonam just keep going there. All right we're into feasibility, Pam?

Pamela Foster: Yes. I didn't think there was anything other than outside what was discussed yesterday for feasibility.

Gerri Lamb: OK, thank you and Emma.

Emma Kopleff: I agree and highly feasible given now that's often routine aspects of care.

Gerri Lamb: Thanks, any other discussion? OK. Poonam?

Poonam Bal: Feasibility is now open.

Emma Kopleff: This is Emma I'm just – I'm going to abstain from this vote just so – that's why the numbers may be different.

Poonam Bal: Thank you for letting us know.

Angela Franklin: Emma, this is Angela. So abstaining is really reserved for if there's a conflict to that you have with the measure I mean you should really vote your conscience on the measure regardless.

Emma Kopleff: I appreciate that, I fear that my feeling, my rating of the feasibility which I believe to be high does not affect the nuance around (of that quite) reflecting the fact that because the feasibility is so high to me it be to the lack of importance. So for that reason I'd like to see permission to not use the numbers.

Angela Franklin: Sorry, just for the record that is not how feasibility is voted on, that's not the consideration behind the feasibility.

Emma Kopleff: Right, but generally if the measure has been voted down on importance which again, you know, it's my understanding as a committee member that was my one vote. And I appreciate that the rest of the committee didn't feel that way. But having failed that unimportance I'm applying the criteria which don't move on pass with that. I don't want to hold this up Angela maybe you and I can talk offline.

Angela Franklin: Very good.

Poonam Bal: OK, so the final results are …

Gerri Lamb: We just lost sound.

Poonam Bal: Oh, can you not hear me?

Female: I've lost you. We've lost you just for a second.

Female: Yes.

Male: Just for second.

Female: Poonam we didn't hear the results.

Poonam Bal: Sure I'll repeat that, thank you. So the final results are 10 high, 10 moderate, zero low, one insufficient, and we do move forward to using usability.

Gerri Lamb: Thanks Poonam.

Poonam Bal: No problem.

Gerri Lamb: OK, usability and use, Pam.

Pamela Foster: Yes, and again I think to add outside of what we have previously discussed.

Gerri Lamb: OK. Emma?

Emma Kopleff: Agreed. Nothing – Other than just to note that I think we've discussed this issue within the measure form I believe the section was – I'm viewing it as empty. So if I'm missing something I apologize, but I think we can move on.

Gerri Lamb: OK, any discussion of usability and use? OK now on to the vote.

Emma Kopleff: I guess again if I might just probe and ask people to offer some justification around how they're voting that would be useful given that the measure form that's in.

Jeremy Boal: In consideration of the whole committee, this Jeremy Boal, I would appreciate it if we would continue to follow the protocol and not allow this call to be dominated by one voice.

Emma Kopleff: I apologize though.

Female: This is (Inaudible). However I want to also ask the same question Emma is asking if our criteria for usability and use to saying not applicable then what is the vote about?

Gerri Lamb: So usability and use are still applicable as we have passed the measure in terms of importance in scientific accessibility. And we do have a number of issues that this committee has previously discussed about these measures as well as measures in this particular category. And we want to have discussion about the parking lot issues as we're naming them right now about why we're getting these kinds of measures, what kinds of measures we'd like to see and why we voted a particular way for a follow up call after this call.

So those issues we're going to capture those, we've captured most of what's been discussed already yesterday. And we will be discussing those in depth on a follow up call.

Jean Malouin: Hi this is Jean Malouin and I would just like to echo the plea to stick with the protocol. I think yesterday was a little bit frustrating for some of us. And think we want to make sure that we make good progress today.

Gerri Lamb: Thank you. It's appreciated and that we would just move on and then we'll have that opportunity. So the vote – the voting is open for usability and use, please vote.

Poonam Bal: OK, I will send you last call for voting and then I'll be making the final vote announcement.

OK, our final results are one high, 15 moderate, two low, four insufficient and we would – we will move forward to the final vote.

Gerri Lamb: Is the voting up there Poonam?

Poonam Bal: Oh, I thought you want to discuss. My mistake.

Gerri Lamb: Oh, OK.

Poonam Bal: The voting is now open.

Gerri Lamb: Oh, OK. All right. We are – We're just moving now to the final vote for suitability based on all of the criteria with the discussion we've had. So let's please just move ahead on this.

Poonam Bal: OK we are at 21. I believe that some people have chosen to refrain so that should be the accurate number. Oh, I guess no more refraining. OK for the final vote is 14 yes, eight no. And this measure will be recommended for endorsing by the committee. And we'll move forward to the next measure.

Gerri Lamb: Thank you. Poonam if you could get up the – OK, 294. Now in the interest of time again and with recognition of everything and everyone is saying about getting through this, you know, I think we all realize there're a lot of issues here. We have four more of these to move through and multiple parts. So please, if you would emphasize what is relevant to the measure please don't review the things that we don't discuss in detail yesterday.

So we're moving on now to 294 patient information Rich you are the primary. If you can just give us you know, like one minute over view the measure before you move into evidence.

Richard Antonelli: Yes, the synthesis 0294 transmission patient information that overview the percentage of patients transferred to another healthcare facility and medical record documentation indicated that patient information was communicated to the receiving facility within 60 minutes of departure. This is also from University of Minnesota Rural Health Center. The – I'm actually going to with the chair's permission going to be very time efficient here because many of issues we've talk about are relevant here but I want to sort to keep us focused on we moving forward with the evaluation of this.

Limited evidence has been really presented in that to support this, however, I do think that is absolutely essential that we sort of think about this in the context for which it – this measure was intended. It actually does represent a critical component of communication. And as we talk about yesterday that is foundational to be able to move toward the demand of care coordination.

So the reliability was assessed as being moderate had some opportunity for improvement over time this also had an expert, a panel validation approach some of the methodologic issue about representation I believe of so-called consumer voices on that panel were noted yesterday. And that's how I would frame this. I know that Jennifer is the secondary person here let her go and I will open it up for comments or questions.

Gerri Lamb: Yes, Jennifer if you would stay with evidence and then we'll move on to reliability and validity.

Jennifer Lail: I think Rich has stated it well I have nothing to add. Thank you.

Gerri Lamb: So if we can open it for discussion of their comment on evidence. OK, Poonam.

Poonam Bal: OK, voting on evidence is now open. OK, so the final results are zero high, two moderate, 14 insufficient with exception and five insufficient and we'll move forward to gap.

Gerri Lamb: OK, performance gap, Rich.

Richard Antonelli: So I guess I've – if the group is comfortable with this let me just say that there's – I don't really have anything new to share specifically for this measure that we haven't talked about already.

Gerri Lamb: Thanks, Rich. Jennifer?

Jennifer Lail: I agree.

Gerri Lamb: You're making both making this very efficient. Any discussion? OK, Poonam?

Poonam Bal: OK, voting for performance gap is now open. OK last chance for voting. OK final results are zero high, 14 moderate, seven low, one insufficient and we move forward to priority.

Gerri Lamb: OK. Priority, importance, Rich?

Richard Antonelli: Again, I offer it as a group a similar discussion in terms of the elements of the presentation for this measure.

Gerri Lamb: Thank you. Jennifer?

Jennifer Lail: Agreed.

Gerri Lamb: OK. Comments? Poonam.

Poonam Bal: OK. Voting is now open. OK, last call for vote. I'm going to give it a second to reset and convert it over. Other numbers?

Female: Hey Poonam we're not over. It's all right.

Poonam Bal: We got everybody voting now? OK. Perfect. OK. So the final results are zero high, 18 moderate, four low, one insufficient and we do move forward.

Gerri Lamb: Reliability, Rich.

Richard Antonelli: With the group's indulgence and same framework, same perspective.

Gerri Lamb: Thanks. Jennifer?

Jennifer Lail: One tiny comment. One thing that we've kind of not discussed is the 60-minute attachment on this and I don't have strong opinions about the 60-minute issue but it seems to fall into the background. So I just want us as we move forward to remember that we're asking for the 60 minutes and know that that may change the reliability of the data based on whether or not everyone measures the time of transmission from the same specification.

So, the 60 minutes, I don't think it's so important in the care of the patient, but I do want us to note that we sort of ignored the 60-minute piece.

Gerri Lamb: Thanks. Good addition Jennifer. Comments? Discussion?

Terrance O'Malley: Hi. It's Terrance O'Malley. The addition of a timeliness metric to this content is I think very appropriate and good and I'm glad you flag that.

Gerri Lamb: Thank, Terry. Any other comments? OK. Poonam?

Poonam Bal: OK. Voting is now (open) for reliability. OK. So the final result is zero high, 16 moderate, four low, three insufficient and we do move forward to validity.

Gerri Lamb: OK. Validity, Rich, Jennifer.

Jennifer Lail: I'm not sure if Rich had to step off. I do think – are you still there Rich?

Richard Antonelli: I'm still here but go ahead.

Jennifer Lail: The phase validity by extra panels on hospital experts is what we have here and I think we need to say no more.

Richard Antonelli: Other than capturing in the conversation of the – that patient perspective on the panel.

(Crosstalk)

Gerri Lamb: And I think that needs to continue throughout. So thank you for that addition, Rich. Any other comments? OK. Poonam?

Poonam Bal: OK. Voting is now …

OK, so the final result is zero high, 13 moderate, seven low, three insufficient which will pass number one to the next measure and I'm sorry, for the next section which is feasibility.

Gerri Lamb: OK. Feasibility, Rich, Jennifer.

Jennifer Lail: I was glad to see in (Jill's) update that they have a new PMI tool for data collection. Good for you.

Richard Antonelli: And for my perspective, nothing additional to add.

Gerri Lamb: OK. Comments, discussion? OK, Poonam.

Poonam Bal: OK. Voting for feasibility is now open. OK, so the final results are eight high, 13 moderate, one low, and we'll move on to use and usability.

Gerri Lamb: OK. Usability and use, Rich and Jennifer.

Jennifer Lail: I have nothing to add.

Richard Antonelli: Yes, I think all of the – everything we've spend to far applies here so nothing new.

Gerri Lamb: OK. Thank you. Discussion? OK, Poonam.

Poonam Bal: OK. Final results are one high, 16 moderate, four low, and we will move forward with this measure to the final vote.

Gerri Lamb: OK. So we are now at the final vote. Poonam you can put that up.

Poonam Bal: OK. Voting is open. OK so the final vote is 15 yes, seven no and this measure will be recommended for endorsement by the committee.

Gerri Lamb: Great. OK. Let's move on then to 295 physician information. Emilio, are you on? This may have been the time that he needed to leave I think.

Male: I think he is coming back shortly but he might want to – oh, maybe he's here.

Juan Emilio Carrillo: Can you hear me?

Gerri Lamb: Yes. Are you there?

Female: Great.

Juan Emilio Carrillo: Yes, I'm back. Thank you very much. Well this is part of the same measure – set of measures and its sufficient information to present as a patient is transferred to another health care facility whose medical record documentation indicated that physician information was communicated to the receiving facility within 60 minutes of departure. And just to re-contextualize that this is not about quality, it's really about timeliness as we minded ourselves recently and it's not about service coordination but it's about record transfer.

It's very important part of care coordination and that sort of has need to be kept in sort of as the background. We, in terms of looking this really down on the evidence as we have reviewed with the other measures, there is no systematic review of the literature, there's no evidence-based guidelines or a clinical practice guidelines. The guidelines on this it's the work of an expert panel whom I should mention was reduced in 2004 which is ten years ago and that's the basis for our evidence and I think that it's very much in keeping with all the prior measures that we have discussed so far.

Gerri Lamb: Thank you. Brenda, anything to add?

Brenda Leath: Yes. Not much but I do want to say that a question perhaps if this is not the appropriate time to say it as the developer unless any thought given to making this more of a composite measure, you know, this fleet of measure this is part of a composite measure, there is something that is similarly endorsed by NQF that addresses transfers from the E.D. to other settings of care. So that's just a question, otherwise I don't have any additional information to add.

Gerri Lamb: Brenda, I think that's – it's an excellent question and the question of composite I believe Angela correct me on this is we are going to look at harmonization and composite issues in a separate call, is that right?

Angela Franklin: That's right, we just have took at what's in front of us at this time.

Gerri Lamb: OK. So Brenda, are you good tabling that until we have an opportunity to do that?

Brenda Leath: Yes.

Gerri Lamb: OK. Thank you.

Richard Antonelli: This is Rich, can I just ask for a little bit more specification on that. Will the discussion around harmonization in fact the – will that be in a – at a high and general level or would we be able to sort of discuss these measures in the context of harmonization and/or composite formation.

Brenda Leath: Yes. We would be able to drill down to this specific measure and harmonization of any additional measures where there's overlap.

Richard Antonelli: OK. So those measures that are now getting voted forward are not precluded from being able to be discussed in those conversations.

Brenda Leath: That's correct and …

Richard Antonelli: OK.

Brenda Leath: … but – that's correct but they're not a composite right now so that shouldn't be a factor in your voting.

Richard Antonelli: Yes. Absolutely. I guess I'm just sort of pointing out that it would have – for me anyway, this probably would have cause less (argue though) if that other conversation were something that we had a framework for, but I'm flying in with faith here on the point that you just raised and I find that reassuring. So thank you.

Brenda Leath: So thank you.

(Jill Plinger): This is (Jill Plinger) and if I could just add one thing we have to had subsequent expert panels and I did some of that information along and I don't know why it didn't get into the information so I'm just looking for that date but

I think it might have been 2008 or maybe even later. So to the first review or comment, it has been put in front of several expert panels since the original one and I'll look for the most recent date if you want me to.

Richard Antonelli: But we have no evidence of that in material we submitted. We only have reference of 2004 but we will – well we welcome that, I'd like to – I think that's important to see.

(Jill Plinger): If so, I think it was sent out to the committee and we can certainly at least forward that to the committee that information about …

Richard Antonelli: Thank you.

(Jill Plinger): … the panels.

Gerri Lamb: OK. And thanks (Jill) for updating that. We'll look for that information in there and Angela if you can get that out to us as well and with that let's – is there any further discussion of evidence?

Terrance O'Malley: Hi. This is Terrance O'Malley. Just get back to Rich's point about the handshake, if you think about the bidirectionality, this becomes an absolutely essential piece of information because who are you going to call when they have question and that information needs to be part of with some.

Gerri Lamb: Thanks, Terry. And I would encourage all of us to and I know that NQF (scout) will document this. Is – this is going to be a critical discussion as we move in to scope and I like the others who are commenting would like to make sure we have sufficient time because I think it speaks to the concerns we have been walking through and to some extent repeating through these whole measures at. So any more comments about evidence specific to 294 – excuse me, 295.

Male: Five.

Gerri Lamb: OK, then Poonam. Let's move.

Poonam Bal: OK. Voting is open. OK. So final vote will be zero high, five moderate, 11 insufficient with exception, six insufficient and that will leave us in a green zone but we can move forward.

Gerri Lamb: OK, Emilio and Brenda, I'm just going to ask you let's just keep moving forward if you have comments specific to the substance and focus of physician information, please share it, the performance gap.

Juan Emilio Carrillo: Well I guess to rearing the point that we haven't brought so far today is that the – what is the gap in urban versus rural? These are measures that, you know, as we know, our rural base and, you know, the importance of clarifying that, understanding that people will use it appropriately, they know that it's only for rural. And another point that we discuss in our sub meeting about a month or so ago is the issue of paper documentation transfer versus electronic transfer information which basically, you know, might differentiate how this performance occurs in a rural setting versus an urban setting on maybe a setting where there are more resources than another.

So these are just things to keep in back of our minds in terms of – other than that, I really don't have anything else to add from previous discussions.

Brenda Leath: I don't have any to add.

Gerri Lamb: OK. Thanks. Any further discussion? OK, Poonam.

Poonam Bal: Voting is open. OK last chance to vote. OK. The final results are zero high, 16 moderate, two low, four insufficient and we will move forward.

Gerri Lamb: OK. Moving on …

Shari Erickson: Can I ask a question of process question?

Gerri Lamb: Of course.

Shari Erickson: So earlier when we went through the evidence, you said we were at the gray zone at that point which I know you'd indicated that on some of the other elements when we were going through them and I guess I'm curious with

evidence being, you know, I must pass element what that means for the measure having new truly (valid) areas.

Gerri Lamb: So what it means is that measure continues to move forward but we would indicate when this measure was out for comment is that a consensus on this particular element was not truly reach such a divide.

Shari Erickson: Oh, OK. Great. Thank you.

Gerri Lamb: OK. Thanks, Shari. Emilio, priority?

Juan Emilio Carrillo: Yes. Again, this is an item that is of national importance. It's a process necessary for continuity of care. This is something that we discuss in the other areas but other than that nothing new to say on this.

Gerri Lamb: Brenda?

Brenda Leath: No, I don't have anything to add.

Gerri Lamb: Thank you. Any comment? OK let's go to the vote.

Poonam Bal: Voting is open. OK, the final vote is four high, 13 moderate, four low, one insufficient and we will move forward to reliability.

Gerri Lamb: OK, reliability, Emilio …

Juan Emilio Carrillo: (Reliability), I mean, there was – it's like really testing done again in rural hospital 75 in the first cut and then at 73 in the second go around and so other than that, there's nothing new to add.

Gerri Lamb: Thank you. Brenda?

Brenda Leath: No, I don't have anything to add.

Gerri Lamb: Discussion. OK, voting please.

Poonam Bal: Voting is open. OK the final vote is zero high, 15 moderate, five low, two insufficient and we will move forward

Gerri Lamb: Validity, Emilio.

Juan Emilio Carrillo: Again, this is an indirect assessment. Not a systematic assessment, it's based on expert panel. No risk adjustment or stratification. Not unlike the previous discussions.

Gerri Lamb: Brenda.

Brenda Leath: Nothing to add. Thank you.

Gerri Lamb: Discussion. OK, let's go to vote.

Poonam Bal: OK, voting is open. OK, final results are zero high, 12 moderate, seven low, three insufficient and we are in the gray zone but we will move forward.

Gerri Lamb: Feasibility?

Juan Emilio Carrillo: Feasibility, there's noting to add from prior discussions.

Gerri Lamb: Brenda?

Brenda Leath: Agreed, nothing to add.

Gerri Lamb: Thank you. Comments? OK, let's move to vote.

Poonam Bal: Voting is open. Last call to vote. OK, the final result is – high, 15 moderate, three low, zero insufficient and we'll move forward.

Gerri Lamb: And usability and use.

Juan Emilio Carrillo: Well, the measure has been used since 2007 and there's nothing else to add.

Gerri Lamb: Brenda?

Brenda Leath: I don't have anything to add, no.

Gerri Lamb: Comments? All right, let's move to vote.

Poonam Bal: OK, voting is open. OK the final result is one high, 17 moderate, three low, zero insufficient and we will go on to the final. I believe we're going to do without further discussion, is that correct?

Gerri Lamb: Correct. If we can just move in to the final vote, Poonam, that would be great.

Poonam Bal: OK, perfect. Then we're open for the final vote. OK, the final vote is 15 yes, six no, and this measure has been recommended for endorsement by the committee and we can move on to 20 – sorry, 0296.

Gerri Lamb: Thank you. OK, we've got two more to go. And as everybody has been emphasizing the same general comments go, we won't lose them, we won't forget them. And so if Dana and Charlie, you could emphasize any comment specific to nursing information or just let us know that the general comments have been covered, OK?

Dana Alexander: Thank you. This is Dana. So this measure has similar description of measure as other measures, percentage of patient transferred to another healthcare facility whose medical record documentation indicated that nursing information was communicated to the receiving facility within 60 minutes of departure.

As very similar in terms of the – I think the framework at this in terms of the importance as is pointed out under particularly the physician information by Emilio as well. So I won't repeat that. As related to the evidence, yes there is evidence for this measure based upon literature, some literature review.

Gerri Lamb: Anything else Dana?

Dana Alexander: No. I will turn it over to Charlie.

Gerri Lamb: Thank you. Charlie, anything to add?

Charlie Lakin: I'll add that I was on mute. No, I think that's fine.

Gerri Lamb: Thanks Charlie. Any other comments on evidence? All right, Poonam, you're on.

Poonam Bal: Voting for evidence is open. OK, we have zero high, two moderate, zero low, 14 insufficient with exception, five insufficient and we will move forward.

Gerri Lamb: Thanks Poonam. OK, performance gap, Dana.

Dana Alexander: Sure. So as related to performance gap, again the intent that this is to close the performance gap in admission and the communications, that could actually result, you know, in an adverse events or harm to the patient. And that again that the nursing assessments and interventions are very, you know, critical to a safe handoff situation.

The challenge is that this measure has no measures related to the accuracy of the transmitted records. Again, it's been stated before this is more about transmission of the records and within a time sequence but not really focused on the quality of that transmission. And that's all I have to say on the performance gap.

Gerri Lamb: Great, Dana, thank you. Charlie.

Charlie Lakin: Yes, I disagree, there are so many places where the receiving hospital facility could be involved in this process that was overlooked. And I just think that's a real limitation that cuts through so many of these areas.

Gerri Lamb: Thank you, thank you. Anybody want to add anything to what Dana and Charlie have said?

Barbara Gage: This is Barbara, just the issue of necessary but not sufficient that this is an important issue, but it doesn't – they're not tapping all of the places that it should be introduced?

Gerri Lamb: You know, I think Barbara that and I'll jump in any others, I think that that was the, you know, exact words that were used yesterday is that tension between where we as a group would like to see the care coordination measures go and where we are right now that I think somebody called this foundational, we really – in terms of the scope of our accountability on this group really will have the opportunity to talk about measures gap, but I think

what you commented on reflects, you know, I think that the general feeling about set of measures we're dealing with right now.

So – just go ahead.

Barbara Gage: Do we – can you remind me how we've been approaching the issue as to whether it's better to have something in place or whether we're holding out for the best?

Gerri Lamb: I, you know, I think we have discussed that in great detail, Barbara. And so to just briefly state it is – is that I think that many people have commented in the previous discussions as well as yesterday about these being foundational and needing to have a base to go forward with the expectation that we will have the opportunity particularly in conjunction with the measures gap group to really look at the scope of where we're going to so that we can really accelerate the movement in this data set. I think …

Barbara Gage: Thank you.

Gerri Lamb: Many people have expressed I think frustration as well as concern that we really begin to capture care coordination in addition to simple transfer of information.

Barbara Gage: Thank you.

Gerri Lamb: (Inaudible) to add anything there? OK, are you good Barbara for the time being?

Barbara Gage: Yes, thank you, I think I'm just getting warm and spacey, sorry.

Gerri Lamb: OK, yes, you know, we will move from these and get into a new measure soon. So hang in there all of you. Performance gap, did we deal with this? I'm getting spacey too here. I think we covered this, we're in discussion now.

So any other comments specific to performance gap? OK, let's move into the vote then, Poonam.

Poonam Bal: Yes, voting is open. OK, we have zero high, 14 moderate, four low, two insufficient, we'll move forward.

Gerri Lamb: Thanks Poonam. All right, let's move into priority, Dana.

Dana Alexander: Yes. So while the measure developers do not really cite priority, it is again – there are statistics cited by such as the joint commission regarding (inaudible) related to communication that would link this measure to a high priority as well as other organizations such as the Institute for Health Care Improvement as well too.

Gerri Lamb: Thanks Dana, Charlie.

Charlie Lakin: No, I think it's undeniably important whether the information transmitted is the important information and accurate in its transmittal. I think it's less easily established.

Gerri Lamb: OK, thanks Charlie. Any discussion? OK on to the vote, Poonam.

Poonam Bal: OK, voting is open. OK, we have five high, 13 moderate, one low, and two insufficient. And we will move.

Gerri Lamb: Thank you. OK, reliability.

Dana Alexander: OK, so the developer stated that the interrater reliability testing was conducted at the critical data, a limit level but the testing results presented to us really not detailed at the data element level. So I wanted to point that out. However, as related to interrater reliability that overall interrater reliability was felt to be more towards the high side. Turn it over to Charlie.

Charlie Lakin: I thought the only – I thought an interesting point was that the reliability between the two tests actually improved and that I suspect some sort of training intervention was included in there that was part of that, but it wasn't reported. And so that's only an assumption. But had they just reported the second test, it would have looked a lot better.

Gerri Lamb: Charlie, did you want to ask the developer of that was just an observation you wanted to share?

Charlie Lakin: Well it might be interesting, but I don't want to take up too much time.

Gerri Lamb: OK. All right.

(Jill Plinger): This is (Jill), yes there was training in the middle one. We identified areas of concerns.

Charlie Lakin: So that will improve you think because you improve the training of the people who code it?

(Jill Plinger): Yes, and we incorporated those, the new training elements into future training so that we would have better concurrence initially with new people coming out of the measures.

Charlie Lakin: Because there was a notable improvement, you know.

(Jill Plinger): Yes.

Gerri Lamb: Thanks (Jill), thanks for adding that info. Any other comments on reliability? OK let's move to the vote.

Poonam Bal: OK, voting is open. OK, last chance to vote. And the final result, zero high, 15 moderate, three low, three insufficient. And we can move on.

Gerri Lamb: OK, validity, Dana.

Dana Alexander: So, yes, as related to validity, I think very similar to other measures and comments before, I will just make mention that it was noted that some face validity is lacking, and that potential treats to validity were not assessed.

Gerri Lamb: Charlie.

Charlie Lakin: Well, as she said they really overlooked the really important and easy opportunity just to involve people on the receiving and the validating of the measures.

Dana Alexander: Good point.

Gerri Lamb: Thank you. Any other comments? OK, let's move to vote, Poonam.

Poonam Bal: Voting is open. OK, we have zero high, 14 moderate, two low, five insufficient. And we will move forward.

Gerri Lamb: Dana, feasibility.

Dana Alexander: So this measure is really (felt) to feasible and that data abstraction really just not appear to place undue burden on the facilities. And again, in line with similar comments as related to feasibility on other measures.

Gerri Lamb: Thanks. Charlie?

Charlie Lakin: (Inaudible).

Gerri Lamb: Charlie can you repeat that, we lost you.

Charlie Lakin: Well I think that that's fine, I wish there's been a little bit more detail on the burden however, but that will affect take up. But I think in general, obviously, people have been using it and the number who've been using it is growing, that must say something about acceptable burden.

Gerri Lamb: Any other comments? OK, on to the vote.

Poonam Bal: Voting (inaudible). OK, so we're going to have three high, 15 moderate, zero low, one insufficient and we'll move forward.

Dana Alexander: OK, as related to usability and use, its felt that this measure promotes transparency and accountability for the standing facility. Again to Charlie's comment, we really don't have a lot of understanding in terms of on the receiving facility, in terms of the use and usability.

Gerri Lamb: Charlie.

Charlie Lakin: Well, I just – it is the (inaudible) and so obviously, it is usable. And beyond that, I wish I know more about the receiving facilities you (inaudible), but she didn't get that.

Gerri Lamb: OK. And that's something Charlie that we need to include on our list of things to consider in gap. I think it goes back to the discussion we were having about handshake and making sure that the feedback loops are correct. And any other comments about usability and use? Poonam.

Poonam Bal: OK, voting is open. OK, I'll give it a couple a seconds to reset in case someone changed their measure. The voting is closed now. OK, we have two high, 13 moderate, two low three insufficient, and we will move straight into overall feasibility. Please vote now.

Terrance O'Malley: This is Terry. I'm signing off now but I voted. So good luck.

Gerri Lamb: Later, Terry.

Poonam Bal: OK, last chance. And the final vote will be 15 yes, 5 no. And this will be recommended for endorsement and we'll move on to the last measure in this section which is 297.

Gerri Lamb: Thanks, Poonam. OK, everybody do jumping jacks in place. We're coming down the pike on this set. We're on to 297. Just a procedural point here, Angela, I want to make sure that as we move from this set into the separate sets of measures that we have sufficient time for that discussion. We have about an hour and a half left.

If we do not complete that, can we move that to the additional phone call that we need for harmonization and so forth?

Angela Franklin: Yes, we can. We definitely can.

Gerri Lamb: OK because I want to assure everyone that even though we're moving through the very similar set of measures and I think we all expected this, is that we won't soon be moving into separate measures and we will have time to discuss them together.

OK, so procedures and tests, Jean and Karen, are you ready?

Jean Malouin: We are ready. So this is Jean. So this, as you mentioned, is the last of these University of Minnesota rural health measures. And this was – the overview

is patients who are transferred from an ED to another healthcare facility has communicated with the receiving facility within 60 minutes of discharge a list of tests done and results done.

So in terms of the importance to measuring report and the evidence behind this, there really wasn't any new evidence submitted specifically in support of this measure. And that's all I have.

Gerri Lamb: Thanks. OK, Karen?

Karen Michael: Nothing much to add. Just one comment though around importance although it wasn't part of the evidence pack. This measure also gets to the issue around duplication of testing and unnecessary duplication of testing.

So I think it has an added relevance there.

Gerri Lamb: Great. Nice addition, Karen. Any other comments? OK, Poonam.

Poonam Bal: OK. Voting is open.

Give us one second. Thank you.

OK, we have zero high, one moderate, zero low, 15 insufficient with exception, and three insufficient so we'll move on. Thank you.

Performance gap, Jean?

Jean Malouin: Yes, with respect to performance gap, there's nothing new to add for this measure.

Gerri Lamb: Thank you. Karen?

Karen Michael: No, nothing additional either.

Gerri Lamb: Any comments? All right, Poonam.

Poonam Bal: OK, voting is open.

All right, one more to go. Zero high, 12 moderate, five low, two insufficient, and while we're in the gray zone we will move forward.

Gerri Lamb: Priority.

Jean Malouin: OK. Yes, in terms of the priority of this item, I think that this is a very high priority item from my perspective as a clinician who's done on the receiving end of patients with missing tests that we have to repeat.

And so I think this is as Karen mentioned, I mean, this is a patient safety issue in terms of causing unnecessary delays in treatment. It's also a cost issue in terms of repeating expensive tests because they weren't done with the patient.

So that's the only comment I have on this particular element.

Gerri Lamb: Thank you. Karen?

Karen Michael: And just one additional point, Jean's points are right on the money. I think additionally, you know, we have to recognize that this is just a process measure. I would love to see further development of something that looks at the quality and accuracy of the information sent and how it's used on the receiving end.

But most quality outcome measures did at one point in time start as process measures. And I think that's where we are with this one.

Gerri Lamb: Great. Karen, it would be so noted that we can come back to that. Any other comments on this? OK, Poonam.

Poonam Bal: OK, voting is open.

OK. Seven high, 10 moderate, zero low, two sufficient. And we will move forward.

Gerri Lamb: On to reliability. Jean?

Jean Malouin: I have nothing new to add for this element.

Gerri Lamb: Karen?

Karen Michael: Nothing that hasn't already been stated today.

Gerri Lamb: OK. Any comments? Poonam, voting.

Poonam Bal: OK, voting is open.

Last call (inaudible).

Female: We're having some quality discussion. Give us one second. We just have to confer that we can move forward. Give us one second. Thank you.

Gerri Lamb: OK.

Poonam Bal: Sorry about that. OK, so we're going to have zero high, 12 moderate, 3 low, 3 insufficient, and while in the gray zone it will move forward.

Gerri Lamb: OK, so we are moving on then to validity.

Female: Hi, this is (Inaudible). I have nothing new to add for validity.

(Crosstalk)

Karen Michael: This is Karen, neither do I.

Gerri Lamb: Discussion? OK. Poonam, get the vote up.

Poonam Bal: OK, voting is open.

Last call for votes please. Thank you. OK, we have zero high, 13 moderate, one low, four insufficient, and we will – while in the gray zone we will move forward.

Gerri Lamb: Feasibility, Jean.

Jean Malouin: Nothing to add.

Gerri Lamb: Thanks. Karen?

Karen Michael: Nothing to add. It's a hybrid measure. We requires (inaudible) but none were burdensome than other measures.

Gerri Lamb: Any further discussions? OK, Poonam.

Poonam Bal: OK. Feasibility vote.

Last call for vote please? OK. We have five high, 12 moderate, zero low, one insufficient and we're looking forward.

Gerri Lamb: Hey, usability, Jean.

Jean Malouin: Sorry again, I have nothing new to add except that I'm happy we're at the end of these measures.

Gerri Lamb: I think that's a common sentiment, Jean. Karen?

Karen Michael: I concur, nothing to add.

Gerri Lamb: Any other comment? All right, Poonam.

Poonam Bal: OK, voting is open. OK. We have – high, 13 moderate, two low – insufficient and we will move forward and we'll go straight to (inaudible).

Last call for votes.

Gerri Lamb: Is there anyone else who wants to vote?

(Crosstalk)

Poonam Bal: OK. We have.

(Jill Plinger): This is (Jill Plinger). I want to thank you all very much for you insights and your comments and we will be having an expert panel here shortly and I will bring forward all of your suggestions then we will also work to update our backgrounds in scientific report but I really do appreciate all of your insights.

Donald Casey: And (Jill), this is Don. We'll have you back when we get into the future direction discussions. So thank you and Gerri, I want to ask a point of order

to Angela, could we just for the record, would it be appropriate to determine who on the committee is no longer with us? Angela. I'm just curious.

Gerri Lamb: Sure, we can (inaudible).

Angela Franklin: Just for everybody to know that we can do another roll call. We do have 19 people connected right now. Earlier we had 18 people and so we are informed of how many (inaudible). If you would like I can let you know before we (inaudible) know how many votes we're expecting. Would that be nice or we want to know now? Any preference?

Donald Casey: I think there is – I think the count is, is it 21 members?

Gerri Lamb: The total committee member is 24.

Donald Casey: 24. So, just a suggestion to document it.

Female: Yes. We will be documenting it.

Gerri Lamb: Thanks, Don. OK. Well, thank you everyone for your thoughtful comments and your perseverance. We all know that it's been – you know it's been difficult getting through this first stage and the first seven measures and it's been a great discussion and now we're going to move on to the last set of five measures. We're going to be starting with 487. Ellen and Colby are you …

Female: Gerri?

Gerri Lamb: Yes?

Poonam Bal: Sorry about that. I need to read out the numbers so that everyone knows. Sorry, I interrupted you. (Inaudible) chance before we continued. So I just want to say that overall we have 14 yes, five no and we'll be recommending this for endorsement.

Gerri Lamb: OK. That's fine. Thank you, Poonam, for keeping us on track.

Poonam Bal: No problem, thank you.

Gerri Lamb: OK. So everybody stand up, kind of shake up those arms. We're going to be moving on to other sets of measures now starting with 487. Just want to check that Ellen and Colby are with us, are you?

Ellen Schultz: Yes. I'm here. This is Ellen.

Gerri Lamb: Colby?

R. Colby Bearch: This is Colby. I'm here.

Gerri Lamb: Great. Thank you. OK. So we're going to shift a little bit because we had started with the Minnesota measures yesterday. Today, we're going to start with the measure developers, saying a minute or two, giving us an overview and I think it was (Sam) who was here from the department of health. Is that right?

(Sam Emapher): Yes. That's right.

Gerri Lamb: You're still here? Thank you so much for your patience with us.

(Sam Emapher): No problem.

Gerri Lamb: All right. So (Sam) is going to – we're going to ask (Sam) to do a minute or two, if you would (Sam), just keep it brief and give us an overview of the measure and then we're going to move, do the same process we were doing with Ellen and Colby and I think in this case Angela let me just check with you, is since these measures are all different from one another, would it work OK if we ask Ellen and Colby to give an overview first before be start going into the actual different votes.

Angela Franklin: Actually it's been working really well for clarity purposes to have them just start with their comments about the criterion.

Gerri Lamb: OK, so your preference is let's just keep going through with the different categorizes and stop and have that discussion is that right?

Angela Franklin: That's correct.

Gerri Lamb: OK, thanks. All right so (Sam) if you could give us an overview of 487 that would be great.

(Sam Emapher): Sure so it's in electronic prescribing measure and it's looking at – all patient encounter is on the previous month that provide and use an electronic health record with EDI capability, that's electronic data interchange, where the event involve a prescribing scenario, how many – what proportion of – of the meds were prescribed using EDI? And the idea is – there have been a couple of studies, one of them probably the RAND study where it showed that electronic prescribing can lead to more legible prescription than overall safety and cost.

And the idea was developing this process measure in 2008 improved safety and lowered the number of errors primarily through, you know, either provider eligibility, and/or easier med – med to a chronic condition, cross checks, then we can improve safety that way. And the idea was to eventually modify this measure. So that when controlled substances such as opioids are used, we can have better tracking of who prescribed a particular opioid. And which patient is receiving them so a patient can't doctor shop and providers know exactly how many prescription that a patient is on and that's the spirit of this particular measure.

Gerri Lamb: Thank you. OK so now we're going to move into the evidence. And Ellen, I think you're primary.

Ellen Schultz: OK, thank you I guess it's an honor to be able to introduce the first new measure in a few days. So overall, the evidence provided for this measure was slow if we follow the algorithm at least as I read it. As (Sam) noted, there were a couple of studies cited speaking to how – how to use the electronic prescribing would relate to outcome such as safety and cost. But there was no systematic review and no assessment of the body of evidence. And I would add that there were not a whole lot of details taken from those sources.

And they were not particularly recent sources. I bring that up primarily because given how rapid the changes are right now in the use of electronic health records, and help IT. I think for this particular measure it's actually

very important to have current evidence. Of course that's always been a (inaudible) from when you investigate something, when you can manage to get it published. If we could argue about whether or not the dates from the study is published or cited here were sufficient. But, you know, I did a really quick and dirty literature for it when I was reviewing this measure for the workgroup.

And then under 10 minutes in (inaudible) I just come up with quite a few systematic reviews that look like they would have some relevance from this question, which weren't noted here so, you know, that is a little bit of a concern to me. But you know, we'll have to evaluate this space on our own knowledge and information that is presented.

I'll stop there until we get to the next criterion.

Gerri Lamb: OK, thanks Ellen thanks for the comprehensive review, Colby?

R. Colby Bearch: No, actually just – I'm going with the same thing in the spirit of efficiency again the antiquated evidence was a concern for me as well.

Gerri Lamb: OK, thank you. Any comments or discussion points on that? OK not hearing any, (inaudible)?

Female: OK voting for evidence is now open.

OK, perfect. All right we have zero high – oops (inaudible) give it a second I just want to make sure there aren't any vote changing.

OK, we have zero high, zero moderate, seven low, one insufficient with exception, 10 insufficient meaning that this measure does not move forward and we will be moving on to 2456.

Angela Franklin: And Gerri, do we feel like we needed any more discussion about it or?

Gerri Lamb: I was going to ask you about that Angela because it seems to me since we voted not to move this forward if anyone would like to comment on this vote, it seemed appropriate. Is that appropriate to our rule here?

Angela Franklin: Yes that's appropriate.

Gerri Lamb: OK, so would anybody like to comment? This measure will not go forward based on this vote?

Ellen Schultz: This is Ellen I would just add that some of discussion we had at the workgroup was around the same issues of whether, you know, this is necessary but perhaps not sufficient step really is getting at a core care coordination versus – versus, you know, being aspirational towards having something additional. And another issue that was brought up specific to this one was sort of a context of the rapidly changing health IT landscape in the U.S. right now. I'm wondering whether this measure might become outdated.

I bring that up because I think it is something to keep in mind for all these measure given rapid changes in healthcare. And just thinking about, you know, in the short term and a little bit more middle term, you know, what is the, how useful will the measure be given the changes that are going forward?

Gerri Lamb: Thanks Ellen. Any other comments? Anyone else would like to make any final comments on this before we move to the next measure?

Female: This isn't in meaningful use is it?

Ellen Schultz: And this is Ellen so there is a related measure and meaningful use. There's an object I believe it's in stage one, which states that there should be that 40 percent of prescribing encounter should use electronic prescribing? And that's in the (inaudible) setting. And so it's similar but it sets a benchmark because that's really what meaningful use objectives are about. But certainly similar kinds of data would be collected in order to document that meaningful use objective.

Female: Thank you.

Gerri Lamb: I think, you know, Angela that's goes back to the portfolio review and the changing landscape that we're looking at – at particularly the electronic record and communication. And I would hope that as we go back to look at gaps, that we – we take a kind of a broad snap shot of where we're at with that.

Because I think the – the particular concern here is that on the rapid change and where – where meaningful use is as well.

Angela Franklin: I've recorded that and hope that will be on our discussion plate.

Gerri Lamb: Great thank you, thank you. Any other comment on this before we move on?

R. Colby Bearch: Gerry, I think we should also bring the results of our discussion and vote over to the gaps group because I think that it's going to fit into sort of helping guide that discussion there in terms of how this group thinks about that type of measure as a good example to get things framed up there.

Gerri Lamb: Great and I don't know whether this was mentioned I know that Lauralei and Sarah were going to bring this in this afternoon. But to just to share with you that three of us do cross over to the measurement gaps group and that Don and Russ and myself I believe that there is only those three of us who crossed those group. That we will also serve as liaison to this conversation and bring it back to this group as well.

Don, did you want to add anything to that?

Donald Casey: Just that that would be an ongoing process. So what we do today, it has to do with consensus development but this committee is doing other things. So keep the lines open as we move forward.

Gerri Lamb: Great. OK and that's really important. All right, so we are going to move then. Poonam if you will to – I think we're going to 2456?

Poonam Bal: Yes.

Gerri Lamb: Med Rec and number of unintentional medication discrepancies that's Brigham and Women's. Do we have anyone from Brigham and Women's with us?

(Jeff Schnepper): Hi. This is (Jeff Schnepper). Can you hear me?

Gerri Lamb: Yes. Thanks (Jeff) for being here. If you would give us an overview of this measure?

(Jeff Schnepper): Sure. I think what makes this measure different from a lot of Med Reconciliation measures out there is that this is actually looking at the overall outcome of the quality of the process. So it's not just did you compare medications, did you check a box that you performed a Med Reconciliation but this is your medication history actually accurate and are your orders then accurate without history errors and without reconciliation errors? And that makes it unique. It is more time-intensive. There are some other measures that are out there and I would say it's analogous to a lot of what the National Surgical Quality Improvement Program does.

Where they have nurses on site at hospitals doing reviews to look at the quality of surgical outcomes and this would be similar probably with a study pharmacist or somebody else to do this kind of work. You know, keep in mind that every hospital in the country right now is compliant with certain joint commission standards around Med Rec and if we're finding that they're still committing you know three hours on average per patient in orders due to Med Rec errors and about a quarter for a patient with potential for harm.

So it is a big issue that you know clearly is not being captured adequately by our current measures of process and why you need to look at outcomes. And we've shown in the variety of studies that you know this kind of data collection can then drive QI effort. So and we laid out I think a five year plan and how we get from voluntary reporting all the way through to you know more mandated reporting at the end and –but you know we already have experienced now probably 2000 patients across about eight hospitals doing this work. So we know we can do it and we can teach it in with you know with some reliability validity.

So I'll stop there and answer any questions that people have otherwise I'll just listen.

Gerri Lamb: Thank you and what we'll do now (Jeff) is we're going to go through all of the different criteria and if we do have questions we will certainly bring you in. OK.

(Jeff Schnepper): That sounds good. I'll be here until about 4:50. Thanks.

Gerri Lamb: OK. Great. Thank you.

(Crosstalk)

Russell Leftwich: This is Russ Leftwich. I think we might describe briefly how the – some things are, works and what the denominator and numerator are and the measure is dependent on a trained pharmacist taking a medication history to establish a pre-admission medication list which is described in the measure of – termed in the measure as a gold standard medication list. That list has been compared to the admission orders medication into the – subsequently to the discharge medications to determine discrepancies and the number discrepancies divided by the number of patients is the numerator.

The denominator is a random sample of discharged patients, adult and you know it is the unintentional medication discrepancies. So the other requirement is that the charges reviewed to determine what medication changes are intentional if you will and that's described as a brief review. So I think picture of the process in the measure.

Gerri Lamb: Thank you. Russ, is there anything that you wanted to check with the measure developer? Did you want to move on from there into the first stage of evidence?

Russell Leftwich: No, just if anybody on the committee has questions now that they've heard that little description (inaudible).

Male: Thank you and I probably should have started with that. So thank you Russ, I appreciate that.

Female: OK and one thing to point out is – go ahead.

Male: If I'm going to assume you saying and describing it, please …

Male: No. I think you described it perfectly. You know, the pharmacist takes the gold standard history, compares it to the admission in the discharge orders that they see discrepancies. They do a chart review to try to figure out if they were unintentional or not. And if they're unintentional then they're graded.

You know, we distinguished between two kinds of errors that the orders are wrong because the team's history was wrong. We call that a history error. If the orders are wrong despite the history being right, we call that reconciliation error.

So for example you knew the patient was on an aspirin. You documented, you're holding on admission for a clinical reason but then you forget to restart it at discharge. That would be a reconciliation error and we distinguished in all the various types and reasons for errors in our metric. But in the end, it's the total number per patient exactly as you described it, so thanks.

Gerri Lamb: And just to point out to everyone while we won't be getting in to the harmonization discussion in the measure review that was prepared from the discussion of this measure a couple of weeks ago, we do have a fairly lengthy document there that we will be getting in to with a fair amount of detail on the review that we're going to be going to. So just to encourage everybody to have that in front of them as we move forward. So Russ if you would move at the primary, I guess Terry is no longer here because he said he was going to recuse himself.

So Russ you're it. So if we can move into evidence and then we'll stop at evidence, have a discussion and then move on.

Russell Leftwich: So there are a large number of studies that Terry and I in discussing it to judge this fair quality but with the consistent results showing the importance of Med Rec Medication Reconciliation. (Inaudible) I think support the importance certainly.

Gerri Lamb: OK. Anything further in terms of empirical support or anything else do you want to add to that Russ before we open it up to discussions?

Russell Leftwich: Yes. I think there's a lot of empirical support and certainly my own experience in practice intuitively that it is very important.

Gerri Lamb: OK. Comments, remember we don't have the secondary discussant Terry recused himself so any comments that people would like to make or questions for the developer?

James Lee: Hi, this is James Lee and I'm sorry that I left the conference call for an hour. Can you show with me the measure that we're currently discussing, what's that?

Gerri Lamb: Certainly we are on 2456, which is Med Rec.

James Lee: Thank you.

Gerri Lamb: The number of unintentional medication discrepancy.

James Lee: Thank you.

Gerri Lamb: You're welcome.

Lorna Lynn: This is Lorna Lynn. I think this is an example of a measure with the developers who are trying to push past the checkbox one sided sort of thing that we have recent seeing and that are the easier ones to do so I just want to put that up there.

Gerri Lamb: Lorna, you want to say a little bit more about moving beyond? How does it do this? So that everybody is clear on the point.

Lorna Lynn: I think through – we have acknowledged that it is more time-intensive that there needs to be training of highly qualified health care professional in doing this but that it's looking at what was happening in the outpatient sphere and then in the inpatient sphere and then moving out again. So, well perhaps not quite a complete handshake, it's moving towards that and it's my opinion.

Gerri Lamb: Thank you. Thank you.

Any other comments on the evidence related to this measure?

Male: Gerri, Don, Russ, remind me because I've been looking at the document. I didn't recall seeing the discreet linkage between the reduction and

discrepancies and the evaluation of adverse drug events in terms of having a reduction, it says there are studies that demonstrate a reduction but I didn't see this link to the measure. Do you?

Male: No.

Male: Yes.

Male: I just (inaudible).

Male: And then, you know, the other thing is that with respect, I mean we've had this discussion before too with respect to medication reconciliation. The linkage to care coordination and I realized we're, you know, we're getting into this gray zone here. But I – it just it isn't quite clear to me. I understand what it is, it seems far more directed at patient safety which of course is part of good care coordination but I just throw that out as a comment …

Male: (Inaudible) as a care coordination in the sense that discharging patient on the same medication as they were previously on. Is in my mind certainly care coordination.

Ellen Schultz: Hello. This is Ellen Schultz. I would just add that, you know, in my mind this is like a proxy outcome or a short term outcome of good care coordination around medication. And it would be the link between a care coordination processes and medication reconciliation and patient safety.

Emma Kopleff: Hi. This is Emma Kopleff from national partnership. Just a small input knowing the measure is in front of us but I think this is an easy thing to address of the developer field is important. But I thought the evidence was extremely well-presented and so I wanted to sort of congratulate the developer and NQF staff for presenting their notes very clearly. The one input I would have from the consumer line is simply just the measure title. But I think there is an easier way to explain this important concept of medication reconciliation to the consumer community. So in the future I hope you'll consider a more lay language. Thank you.

Female: Thanks, Emma.

Male: Thank you.

Female: And just a comment here I think that Don was raising that I don't seem summary notes. Was the issue when organizations go through the whole process does reducing their unintentional discrepancy actually reduce errors in the long-term and patient outcome. So what I think that may speak more to usability. But I didn't see it in the comments here. We just like to have Don's comments for the record.

OK any other comments about evidence? All right. Poonam.

Poonam Bal: OK. Voting is open. Last call, we should have 19 for voting. Get a couple of votes in. That will be great. Thank you.

Female: Angela, we seem to have lost some more people or at least more people aren't voting. We still have a majority. Are we still good?

Angela Franklin: Yes we can continue. (Shawn) can you confirm how many was (inaudible).

Operator: We are checking now it looks like we've had a couple people who's connection have been coming and going. I'm checking your accounts now.

Gerri Lamb: We lost Marcia James a few minutes ago.

Angela Franklin: OK. So these are the numbers. Yes, we can continue.

Poonam Bal: OK.

Gerri Lamb: OK.

Poonam Bal: So the numbers are zero high, 15 moderate, two low, zero insufficient with exception, zero insufficient. And we will move forward.

Gerri Lamb: OK, Russ we're going to talk about performance gap.

Russell Leftwich: In performance gap the study that's reported of six institutions were this process was used. So that's a variation between of the sites for the per patient

medication discrepancies of a range of 2.78 to 4.57 with an average of 3.44. So there is evidence that there is a performance gap.

Gerri Lamb: OK. Anything else, Russ?

Russell Leftwich: Well, there are number of studies – reported that show that intervention and medication reconciliation improve the medication reconciliation outcome process accuracy. So I think that it supports a performance gap as well.

Gerri Lamb: Thank you. Any other comments on performance gap? OK, Poonam.

Poonam Bal: OK. Voting is open. OK. We have six high, 11 moderate, zero low, zero insufficient and this will move forward.

Gerri Lamb: Thank you. Priority, Russ?

Russell Leftwich: The nationwide data that's presented in the by the developer shows the significant variation in medication discrepancies and this clearly seems to be an overall problem. That as we've noted doesn't, if there's not a clear link next to outcomes but there are some study showing increase utilization after discharge related to medication discrepancies or medication errors.

And the developer does provide evidence that this is the single largest source of medication errors in the hospital is these discrepancies and medication reconciliation. That's why I think that there is a moderate or high. It's not priority of this.

Gerri Lamb: Comments, question?

Ellen Schultz: I would just add to that, that I think I can safely say that every single patient who is hospitalized is going to have some medication used and will therefore require some amount of medication reconciliation upon arrival and upon discharge.

So in terms of, you know, how cross cutting this is it's seems to me very, very high and applicable across a huge (swat) of our patient population. And the hospitalization is one of the most expensive ways to deliver care that it would also be high priority from cost stand point as well.

Gerri Lamb: Thank, Ellen. One of the questions that I had is – and I think we've discussed this in the group and I don't see it on here is this measure is not risk adjusted. And whether there would be usefulness down the road in terms of its importance and priority, if there was a link between the more medications you're on that you're more likely to have discrepancies and it's really just a question of wonder in terms of whether that would enhance the priority for very high risk individuals.

Russell Leftwich: There is evidence although the measure not risk adjusted but there is evidence presented by the developer that the number of medications does increase the risk of discrepancies.

Gerri Lamb: OK. Thanks, Russ.

Donald Casey: Gerri, good point to the extent that the (stun) of the evolution of the electronic medical record and all of it's attendant build in whistles is present in the organization in 2014 would probably – I'm guessing effects – affect us, but in more fundamentally in we've talked about this on prior committees relative to Med Rec. I know the measure developer addressed some of these but part of the challenge with Med Rec as we all know is that it is good at sort of tactically listing the meds but not getting more fundamentally at the appropriate usage and need before the meds, you know.

So for example the 85-year old who's on Lipitor because just because they've on it for 15 years and has no benefit from it is an example of where, you know, these things get recorded but not maybe aggressively addressed. So it just trying to make the point between the process of Med Rec and the critical thinking behind the appropriate usage of medication including the risk of adverse drug events which I know the measure developers will also – because their pharmacist very interested in but practically speaking might create some limitations here.

Gerri Lamb: Thanks, Don.

Russell Leftwich: I guess I would also point out that is come to my mind that the in terms of priority, the output of this final reconciliation that is that discharge

medications are the input for the reconciliation and the next setting up here. And that high risk population of patient's going to long-term post acute care settings, I think having accurate input for that – the next medication reconciliation is that a priority.

Gerri Lamb: Thank you, thank you. Any other comment on priority? Hey, Poonam.

Poonam Bal: OK. Voting is open. Last call for those just in case please put in again. We want to make sure we're going to get the accurate number. And we are looking for 16 votes. Thank you.

All right. So we have 11 high, four moderate, zero low, zero insufficient. And we will move forward.

Gerri Lamb: Thanks, Poonam. All right, Russ, reliability.

Russell Leftwich: Well, first I think it was difficult for me to find or determine exactly that these – the specifications around the pharmacist training to train pharmacist to produce this goal standard a list and the actual steps to producing it. I guess also with respect to reliability there is one exclusion and that is patients that are discharged before the goal standard preadmission medication list can be obtained.

The other I think issue around reliability is the suggestion of the developer that didn't – the measure be applied by selecting randomly essentially one patient a day on weekdays for a total of 25 patients in a facility to include in the denominator. And I – I'm not a statistician but I wonder if that's – if that produces the same reliability across institutions particularly since we discussed the risk – the potential risk stratifications of (facility) has relatively young patients or relatively old patients that random sampling of 25 patients somewhat might produce different reliability. At least that was my analysis.

Barbara Gage: So the cases were – this is Barbara – the cases were randomly selected across the month. So that takes care of any bias associated with certain days of week or start or end of month.

Russell Leftwich: No. They were (inaudible) the suggestion of the developer was that they'd be weekdays.

Barbara Gage: OK. And the …

Russell Leftwich: Might reduce the (inaudible).

Barbara Gage: It might although patients aren't typically – or are less frequently admitted and discharged over the weekends except for late Friday. Is there any volume adjustment like it's a 25 cases per site regardless of what proportion of admission that equal that took place?

Russell Leftwich: That was my understanding at the suggestion. 25 patients without respect to the size of the institution.

Barbara Gage: Do either of you wish to address a question the measure developer?

Russell Leftwich: Right if we – if there's any clarification on that, I would welcome it.

(Jeff Schnepper): Hi. This is (Jeff Schnepper). I mean both of these things were done, you know, for the convenience and ease of implementation. So your obviously, you know, tying to walk a line here between, you know, reliability on one hand and feasibility on the other.

You know, I assume, you know, at this point, you know, for voting and the measure is what it is, but you are right, I mean the way we've done it is one patient per day during the week regardless of the size of the hospital which, you know, certainly does get sampling issues.

You know, in our five year plan we did talk about, you know, potential roles for risk adjustment going forward, you know, which would partially address some of the issues that you just raised based on age and number meds. But again, you know, we were trying to walk a line between feasibility and reliability.

This is what we've done with our, you know, six hospitals in our study. So we know that it can be done this way. If you ask larger hospitals to do more cases, you know, would it be feasible? Possibly, you know, I – but, you

know, for now for voting purposes I assume the measure has stay as it is. But that was is why we made the decision that we did. It was really interest in feasibility.

Barbara Gage: Yes. And this is Barbara. I have to admit, as someone who's been in the measurement development business also, it's not a bad approach. You do phase constraint in terms of the provider's willingness to do the extra data collection extra and addition to their regular work flow. So at least you were collecting a set number per day across different days of the month. It's not bad.

Russell Leftwich: So …

Gerri Lamb: Any other – go ahead, Russ.

Russell Leftwich: In terms of the (inter-relater) – inter …

Gerri Lamb: Radar?

Russell Leftwich: … radar reliability – thank you. There was a – it seemed to be relatively small sampling with 19 patients and – but with at that it did show reliability that fell in the acceptable range.

Ellen Schultz: This is Ellen Schultz. I'd like to make a comment on that. One concern I had with the method of reliability testing was that it compared their reliability at two different pharmacists at a single site. But actually when you think about implementing this measure in a wide spread at many different sites, what I actually care about, at least as much if not more is the reliability from one hospital to another.

So can you show that, you know, pharmacist – whatever training is going to available to those who want to implement it? Using that training then can pharmacist at one hospital reliably implement this compare to pharmacist at another hospital so that basically you're preparing apple to apple if you're going to be comparing hospitals.

Because if you think about an accountability use as this measure which is one of the criteria for NQF that you have to be able to make those kinds of comparison. And I didn't see anything that spoke the reliability across site rather than just reliably present one single site.

Male: Would this measure developer here to comment on that?

(Jeff Schnepper): Yes, that we've done a lot of work on that recently. I think some of it made it into the applications, some of it might not have and I apologize. We have standardized cases now which we do and can be done actually over the phone where you have someone role-play a patient and the person basically take the history on that patient and we look at their ability to ask, standardize set of question used prompts, access additional sources of different information when needed, know when to stop, reconcile all those sources against each other, go back for confirmation with the patient the second time and then put together a gold standard medication list.

And then, we can measure both how they did in terms of the behaviors that they required to do, and then, the gold standard list that they come up with at end matching ours. And that we do that now with all of our pharmacist that we train across our sites.

The other thing that we do is that every quarter, one of the pharmacists submit a case. And then, all the other pharmacist in all the other sites do and then independently give us our results and we discuss the cases on the phone.

So we keep getting better at this process. I'd say both from the history taking stand point and then just from the recording and evaluating standpoint across our sites. We feel pretty good about consistency at this point. And again I thought that something that we're not making into the application it's more recent than that.

Gerri Lamb: Thank you. You know, that's what (Jeff) is asking, (Angela), if you could give us a clarification here in the spirit of we review what we have. Can you remind us on this vote? Is this a must have vote? Does their – is there an exception so that we just know what the implications are?

Angela Franklin: Typically, must have (inaudible).

Gerri Lamb: OK. So the scientific acceptability must have with not exceptions. OK. So everybody is clear on that as we move forward. Any other comments on reliability? OK. Poonam.

Poonam Bal: OK. Voting is open. OK, we have (five) (inaudible). OK. I'll give you a couple of seconds to make sure (inaudible). OK, we have zero high, 14 moderate, two low, zero (inaudible) and we will move forward.

Gerri Lamb: Thank you. OK. Russ, validity?

Russell Leftwich: So the indication by the developer is that the validity testing which performed at the performance measure score with systematic assessment of the phase validity. There's literature sited to support that the process of pharmacist taking medication history is superior to physicians, nurses, other personnel taking medications histories.

And that they consider a proxy for the gold standard process that is referenced in the measure. The sample – that test sample in their validity testing does once again seem small. And we've referenced earlier the linkage between the measure and the outcomes or adverse outcomes is – there is not a strong support for that in terms ultimate validity.

Gerri Lamb: Thank you. Any other comments? OK. Poonam?

Poonam Bal: OK. Voting is open. OK. We have five moderate, three low, zero insufficient, (inaudible).

Gerri Lamb: OK. And we seem to – just for the record, we seem to have lost more people.

Poonam Bal: Yes, that's correct, (inaudible).

Gerri Lamb: OK. All right. Feasibility. Russ?

Russell Leftwich: So feasibility, I think is – there are some considerations more so than with some of the earlier measures we have looked at, is the data generated during care. We'll the medication reconciliation is in the list that results from it that

the admission medication and discharge medications. But the data for the measure really is not generated during (toward) this goal standard medication list. It is not.

And that is I think the significant consideration in the feasibility. It was obviously feasible in the academic institutions where the studies that are reported were done using this method. But whether it's easily or it's feasible in community hospitals, smaller hospitals – and I think that's the question.

Gerri Lamb: Thank you. Any other comment on feasibility?

Russell Leftwich: I guess I would add that there was in some of the evidence presented, the evidence that medication reconciliation is – and the discrepancies are lower when electronic records with electronic medication list if you will are involved.

Gerri Lamb: Thanks. Other comments?

Ellen Schultz: This is Ellen. I have a question for the developer before sharing some other thoughts. So you mentioned training and a lot of support that you've provided thus far to sites – to really help them in implementing this. Are you prepared or do you have plans for, how to scale up that at much wider scale to anyone who is interested in implementing this measure?

Male: All right. Thanks. In response to one of the other comments, I would just add that or actually, our most successful sites were actually small community hospitals. In our study, one of the sites has a 100 beds, the other has about 400 beds and they're non-teaching community hospitals.

Getting to your question, we are prepared to scale up and have sort of outline that in the four or five year plan and how we sort of do the teaching in mass and sort of how to do this whole process. But hat's the thing we're most excited about actually is sort of going the scale with this whole process.

So but – yes I mean between, you know, webinars, courses, you know, there's a whole of bunch of ways that we can do at a large scale. We actually have a proposal right now to at least increase the number of sites from six to 30 but

you know, after you go to 30, you go to 300. So I think it's feasible for us to do. Thank you.

Male: I have a related question that occurred to me. And it's my understanding that pharmacy technicians have been demonstrated to help superior performance in medication reconciliation to nursing personnel. I think maybe even physicians. Has there been consideration of using that resource as opposed to pharmacist?

Male: Yes, that's a great question. Certainly, pharmacy techs are part of the solution. Our most successful sites are the ones that ended up having pharmacy technicians trained as what they call Med Reconciliation assistants in their emergency department is taking medication histories before the patients get admitted upstairs.

And I, you know, personally I think any hospital that can make substantial improvement it's reconciliation processes is probably going to end up doing that. Now, whether they should be ones taking the quote unquote "gold standard medication history for quality measurements", you know, I think – would probably take a little bit more work to prove that they do it as well.

I mean most pharmacy takes to do it with pharmacist oversight. I think they probably are capable of doing it well. We made a decision not have and take the gold standard one or although I can say they're certainly part of the interventions to improve care. And I don't think we're prepared to say that yet that they would be part of the measurement for the actual quality measure.

Gerri Lamb: Thank you. Any other comments about feasibility? Ellen, did you have additional things you wanted to ask beyond your question to (Jeff)?

Ellen Schultz: Yes, I did. And I, you know, I don't want to dominate the conversation here but I'll just share, you know, when I initially reviewed this, I was very, very concerned about feasibility in terms of implementing this in practice because the measurement burden is much higher than most of the quality measures, you know, that are out there and that are acceptable and in terms of their measurement burden.

But I have to say – and thinking about this further, I'm hearing comments from the developer and just in light of our entire conversation in terms of, you know, being aspirational about care coordination. I think that the measurement burden here really is justified by the advance and moving forward and getting to really the outcomes and the quality and that, you know, this really incorporate a lot. Some hand shake idea we've talked about but however, the medication reconciliation process is done.

You know, whatever the local the local internal processes are that they – the effectiveness of those processes will be reflected and the outcome that's captured by this measure. So to my mind, I think that justifies the measurement burden. I would love to hear comments from other committee members about their own thought process on that because we especially consider how do we move the sales forward.

Gerri Lamb: Anyone care to just comment?

Jennifer Lail: This is Jenifer Lail. I have a question on page nine of your summary statement. It says on item six, the main barrier to data collection has been availability of the study – pharmacist study to site. It sounds like you're pretty well resourced. Do you have ideas about this is to the developer about how that might be addressed in other situations?

Donald Casey: Gerri, this is Don. I don't mean this type the conversation but I think we're getting into the discussion off of the – what was presented. And I think this is a good futuristic comment but we only have 12 minutes and we have to public as well before we jump so …

Gerri Lamb: OK. With everybody's kind of OK here, I think we will move forward on this. It's a very thoughtful conversation and so – and really appreciate the input of the developer. If everybody is ready, we need to finish this vote so that we can open it up. We will not do the three CMS measures. We have lost several people in this process. So with, you're OK – Poonam, if we can go into feasibility?

Poonam Bal: Of course. The voting is open. OK. We have zero high, 11 moderate, four low, and well – I'm zero insufficient. And while we will go, we will move forward.

Gerri Lamb: OK. And, Russ, if you can give us just a quick overview of usability hit a high spot for us because we do need to open for a public comment.

Russell Leftwich: Yes. I think in terms of improving quality, that evidence is presented that does improve the quality of by reducing the number of discrepancies and medications and there is a proposal and in by the developer to use this over a five-year plan as was mentioned earlier for accountability.

Gerri Lamb: Thank you. Any other comments to add for usability? OK. We'll go on to vote, Poonam.

Poonam Bal: OK. Voting is open. OK. Last call.

OK. We have three high, 11 moderate, one low, one insufficient. And we'll go ahead straight to the last vote.

If everybody could for our overall suitability. OK. Last call for vote.

OK. We have 13 yes, two no, and this will be move forward for recommendation for endorsement. And at this point, if you're ready for public comment, we're ready.

Gerri Lamb: That's great. And let me just thank the measure developer. (Jeff), thank you for being with us and thank you for answering our questions.

(Jeff Schnepper): Thank you. I really appreciate it – very happy.

Gerri Lamb: OK. So shall we move on to opening up for public comment?

Operator: To ask a question or like to comment, please press star one on your telephone keypad.

And at this time, there are no comments.

Gerri Lamb: OK, and my understanding, Angela, Wunmi is that we still have three of the CMS measures to get through plus the discussion on harmonization, as well as composite and on measures gap. That's correct?

Angel Franklin: That's correct. And Wunmi. Wunmi?

Wunmi Isijola: Well we will be in the next common days are reaching out to the committee members. And so, we can schedule a call to discuss the remaining measures as well as the topic areas that you just mentioned. We do in fact appreciate everyone's input. And it was a very interesting and very robust discussion.

Given the low number of voting numbers, we will be following up like a SurveyMonkey survey to gather the remaining voting numbers. We will also be compiling some measure discussion points so that you can reference that in your voting decision. But once again, we will be following up with you guys for next step in regards to the project. So thank you again for participating. Angela?

Angela Franklin: No. I think that sums it up and if we're ready we can move to public comment.

Wunmi Isijola: We don't have any.

Angela Franklin: We didn't have any. OK.

Gerri Lamb: Wunmi, can you clarify the SurveyMonkey is only going to out to the people who were not here, is that correct?

Karen Johnson: Yes. This is Karen. Sorry. I think how we'll work it is we'll figure out which people left before that last vote …

Gerri Lamb: OK.

Karen Johnson: … and that's for them.

Gerri Lamb: All right. And then, we will plan to do the CMS trio and then move on from there and I think just to repeat again, thank you all for staying to the bitter end here and for your perseverance getting through the initial set. And such as

thoughtful discussion and it will be not lost. We will move it forward into the gap discussion.

Karen Johnson: I think we will …

Angela Franklin: And Gerri and Don, thank you for your expert co-chairing of these calls. And we've really appreciate your participation, your co-chairing.

Gerri Lamb: You're welcome.

Donald Casey: Thank you.

Gerri Lamb: All right take it easy every one. We will be in touch.

Male: Thank you. Bye-bye.

Female: Thank you, bye-bye.

Female: Bye-bye.

Male: Thanks

Female: Bye-bye

Female: Bye-bye.

Operator: This concludes today's conference call. You may now disconnect.

END