NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
January 31, 2014
2:00 p.m. ET

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

Angela Franklin: Hello and welcome to the second series of our Care Coordination Consensus Development Project Tutorial Call. My name is Angela Franklin, I'm the Senior Director for the project and I have with me here our project analysts (Vera Shehad). And we – the purpose of our call today is to go over any questions the committee may have as they've reviewed the committee guidebook about measure evaluation. But first we'd like to find out who's on the call. And we'll just – if you could just let us know, committee members, who are on the call.

Lorna Lynn: Hi. This is Lorna Lynn from ABIM.

Angela Franklin: Welcome.

Don Casey: Hi, Don Casey from the American Collage of Medical Quality and IPO for Health.

Ellen Schultz: This is Ellen Schultz from Stanford University.

Russell Leftwich: Russ Leftwich from the State of Tennessee.

Angela Franklin: Hi, Russ.

Richard Antonelli: Rich Antonelli, Boston Children's Hospital.

(Carrie Erickson): (Carrie Erickson), American College of Physician.

Angela Franklin: Thank you.

(Terry O'Malley): Hi, (Terry O'Malley), Partner's Healthcare Boston.

Angela Franklin: All right.

(Jean Malowen): (Jean Malowen), University of Michigan.

Angela Franklin: Welcome. Are there any others that we have missed?

OK. Hearing none, I'll move on to – just to open the floor and ask if committee members have specific questions about the measure evaluation on criteria or process. OK. Great.

Hearing none, I'll move on. What we wanted to do today was simply go through a measure that's in our portfolio and for review and just talk about what we've – the expectations of the steering committee as we go through, just quickly overview of the major endorsement criteria.

Again, they are important to measure and report and the goal there is to measure aspects with the greatest potential of driving improvements. This is a must pass criteria of reliability and validity that is the scientific acceptability of a measure. And the goal of course to make valid – to make sure that the measure will make valid conclusions about resource use, feasibility which the goal here is the cause of little burden (inaudible) and usability and use.

And that's to be sure that decisions related to the decisions that the measure evaluates are related to accountability and improvement. And if measure's not useful we probably won't care so much about feasibility. Once the committee has reviewed these major criteria, then if there are related measures, the committee will assess to what extent those measures are harmonized or need to be harmonized. We do not have any competing measures in this round of measure review.

So next, as we walk through, please note that the sub criteria underneath these major criteria are meant to demonstrate that the major criteria are met. And question you'll ask yourself is how you know the measure's important and scientifically acceptable, et cetera.

If you're streaming this, you might want to mute your phone lines. Thanks.

So we do have some assist to the steering committee as we go through. We've created several algorithms, three in total, to help the steering committee with this assessment of each measure they go through. And we also have instituted a new process by which the staff completes a summary of each measure, a brief summary to assist this steering committee in its review.

The steering committee will have to be – use its judgment and expertise however in assessing and rating each measure. So today where we're walking through the measure information form for measure number 0495 (median) time from ED arrival to ED departure time for admitted ED patient. And that's up on the slide in front of you.

And just quickly to familiarize yourself. You'll see of course that first brief information section where you'll see the stewards, the brief description of the measure, and the rationale for measure, and here the rationales that reducing the time patients remain in the ED is expected to improve access to treatment specific to the patient's condition and increase quality of care.

This measure is also intended to address in part the underlying problem of emergency department crowding. So here you often will see brief descriptions in numerator and denominator and exclusions along with the types of data force and level of analysis. It's good to note here that this measure is not paired. And it's not required to be reported with other measure. However the measure is intended to be looked at in conjunction with some other related measures, measure number 0495 which addresses total time in the ED and 0497, time in the ED after the decision is made to admit patient.

The developer intends this trio of measures to present more complete assessment of this issue. This is not a composite so we'll move on.

Don Casey: Hey, Angela, this is Don Casey …

Angela Franklin: Hi, Don.

Don Casey: … co-chair. And again, I apologize to you and also to the committee members for being partially absent. I was on the road doing business and had a little bumming and vacation from the abhorrent winter in Chicago. But I'm back in action and I wanted to – and if you'd covered this – my question before we get into this because I think it's a good place to talk about it – please let me know. But, you know, I think that given my experience through several iterations of this effort, the first thing that I think is important for the committee to keep their eye on is looking past the measure specification.

So the ones you just put up sort of in the beginning which would be the importance. The measure information formed on the page above.

Angela Franklin: Right.

Don Casey: Clearly, kind of gives us the rationale for the measure. And I think everyone in this call would be, you know, probably agreeing just in kind that this important measure. But what I'm hoping we do in this process is to sort of keep at a higher level the question of whether the committee believes that cast what the intent of the measure is. That it's achieving the intent of us getting effective care coordination.

And, you know, this is a topic that's come up in other steering committees around this issue. So that's not necessarily say that that's by itself a separate criteria. But we should really keep our mind's eye on looking task what the measure developer says and thinking in terms of our own knowledgeability, experience and expertise, how well a measure like this would promote care coordination. And of course we know too that care coordination never occurs with one action. It's always a series of actions.

So without getting into the question of whether this is part of composite, the other idea that I have in terms of the way I'm sort of starting to look at all these is whether in the context of whatever part of the system we're looking at, in this case, emergency department care, whether it's necessary but not

sufficient. Now, that's different from whether they are paired with other measures. So I'm just trying to get the committee maybe to think a little bit outside the box.

You know, we may end up endorsing this as a valid measure of care coordination because we think it's important but I think having those two thoughts intention as you – the committee members look at this would be useful. I also spoke to (Lorelei) about another issue and I believe that we probably have covered this recently enough that we probably don't need to worry about it but given all proposed view that's gone around this whole business of conflict of interest.

I think – and I know it keeps working on this. I think we should probably periodically have a verbal affirmation that none of the committee members have any new information to share with the committee relative to any potential conflict of interest. And that includes both on the measure development, having for example some proprietary interest in the measure moving forward or, you know, some other potential conflict as it relates to the committee members' relationship with NQF and the industry as an example. So I don't think we need to do that today but I just wanted to throw that in there for the record for the committee because I think there obviously is going to be growing sensitivity about that so I'll shut up.

Angela Franklin: Thanks, Don. That's a good point, in fact the context is excellent about looking past, you know, what's the measures say and what the committee bring in the committees expertise and judgment to bear on determining whether this is – what the measure actually does. And with regard to conflicts both exactly on point, we will course at our in person meeting. We're going around the table in disclosing any new information any potential conflicts. And we also would urge that the steering committee members who are – maybe have a question about conflicts with themselves or with another committee member, just bring it to the staff and our general council and we will vet it there.

Don Casey: OK. Right and the usual sort of mindset is that if there's any doubt in your mind about these committee members, then it's worth it without feeling as

though you're going to be putting yourself into a position of accusing yourself for many activities to just ask the question on staff and get a judgment about it. So don't view this as sort of a bad mark but just sort of being transparent and honest. So we'll leave it at that for this call.

(Terry O'Malley): Hi. This is (Terry O'Malley). Just a two points, no conflicts but the idea of sort of looking beyond the measures, I wonder if this does meet your criteria. I looked at this and I followed certain two balance thing measures sort of unintended consequences of tracking the time in the ED. And one might be the kind of data the increase more people than perhaps is necessary. And the second is to move people out of the ED faster than necessary with the result of increase returns and increase admission and both of which would be detrimental to coordination of care. I like to bury behind us but I'm just wondering about unintended consequences.

Angela Franklin: And that is an excellent point as well. In the measure information form the developer has a direct access and said that they have not identified unintended consequences. But here again this is where – just the thought in consideration deliberation of the steering committee as a group to come to a conclusion so whether there are unintended consequences that should have been examined.

Don Casey: Yes, so this is Don. But I didn't mean to disrupt the flow of this but why don't we let the staff go through this one and then why don't you make notes yourself and then we can have a discussion after we've gone through – certainly stop if there are any questions but …

Angela Franklin: Yes.

Don Casey: … in terms of the discussion points which you just raised which are excellent, I think, I guess (inaudible) we could do that at the end of this.

Angela Franklin: That's correct or ask questions as we, you know, complete the whole piece of the form. And I'd also note that we're not evaluating the measure today. I'm just kind of raising thought from questions for the committee.

Richard Antonelli: Yes. This is Richard Antonelli. I wanted to make sure that I didn't miss the message from that busy hotel lobby on Monday. The purpose of this exercise

is actually to go to learn about the process of evaluating the measure. This has nothing to do with the specific measure but we can ask questions about the process to the degree that a content related question or guidance there about sort of looking beyond the specifications as important but do I have that right that the goal of this …

Angela Franklin: Right.

Richard Antonelli:… call is really a how to, correct?

Angela Franklin: That's correct.

Richard Antonelli:OK. Good. OK. Thank you.

(Brenda Liss): This is (Brenda Liss). I am just trying to let you know that I was on the call during the roll call but you couldn't hear me. I'm sorry.

Angela Franklin: Great. Thanks, (Brenda). We have you down.

(Brenda Liss): All right. Thank you.

Angela Franklin: Good to see that you're joining. So are there any additional questions?

(Kobe Birch): No. But this is (Kobe Birch). I think I missed the roll call as well.

Angela Franklin: Great.

(Mia Foster): And (Mia Foster). I did as well.

Angela Franklin: OK. Any others? So I'll try to make this as plain much as possible but let's start with in the spirit of understanding that we're just looking at the how-tos and going through the measure about. Let's start with evidence and that's criterion 1A, evidence to support the measure focus. And for this piece, this is such an important piece we have an attachment that we have actually measure developers to now submit that really is supposed to clarify the evidence and whether it supports the measure focused.

So at the top of this attachment – the evidence attachment – specific instructions are laid out and a special note is a second box which gives the developer and the committee specific guidance related to evaluating the evidence presented to support the measure or the focus. For this measure, a profits measure, committee members should be looking at whether just the developer presented a systematic assessment and grading of the quantity, quality and consistency of the body of evidence and that the measure lead to a desired health outcome.

Now we do prefer that systems for grading the evidence such as the U.S. Preventive Services Task Force or the grading of recommendations assessments, development, and evaluation guidelines, those are grade guidelines. But that is not the only methods that we accept. So let's scroll down to 1A and this is 1A-3 which is applicable to this measure. And here we do ask the developers specifically lay out steps between the measure focus and the health outcomes and this has helped to assist the steering committee with evaluating the pathway.

The developer here has laid out the pathway reducing the time patients remain in the ED, can improve access to treatment, increase quality of care and that reducing this time potentially improves access to care specific to the patient's condition and of course increases the capability for physicians to provide additional treatment. So the committee will have to use its judgment in determining whether the pathway here has been sufficiently established and that of course this locks up the committee.

Then moving on, we want to review the systematic review on the body of evidence presented by the developer whether that's a clinical guideline or the USPSTF recommendation or any other source of evidence. Here the developers indicated another source of evidence so scrolling down to 1A 8. There – I'm sorry – 1A 6.

The developer has provided citation and the committee will have to decide for this process in the many outcome measures whether they feel like the quantity, quality and type of studies is sufficient. We also asked that developers evaluate and show any study design flaws or biases. The steering

committee will have to decide whether that sufficient or needed in this case. And the steering committee will also have to evaluate whether the studies that are presented provide a consistent relationship between the care process and the desired patient outcome.

Like I said earlier, published empirical studies with the systematical review and grading are preferred but we understand even those aren't equal.

Don Casey: So Angela, this is Don again. Can you just …

Angela Franklin: Sure.

Don Casey: … go back up a little bit to where this was because this is going to be important for the committee right there. And, you know, yes, they have a systematic review. So if you remember that Angela showed you I think four different categories and this one was marked other in. So here's an example of where citations were provided. Now, I haven't familiarized myself with these but it would be useful in this case for example to have perhaps maybe a sub group and we can figure this out when we get into this type of arrangement.

Evaluate just to the high level these references because as she pointed out what we're really looking for is both systematic review and systematic grading and ranking of evidence in the accordance with a variety of different measures. Those of you that are familiar with US Preventive Test Service – US Preventive Services Task Force recommendations in terms of how they get pouched as well as the grade system where other bodies that create guidelines for example in performance measure that use different rankings like ACC, AHA, ACCP, and others.

You know, it should be, mindful that the there is a hierarchy here to think about and for those of you that are on the committee that are less familiar with this, I believe there is some background information that may or may not have been shared with the committee already about this. So I just think it's – as Angela has pointed out and (Lorelei) has confirmed, we're really trying to move ourselves into the higher level of evidence which is not to say we're going to leave behind things that have more qualitative spin to them is in fact we think these are really, really important.

So it's just again another tension for you to keep in mind. Pay attention to that set of check boxes because, you know, for example if you're not familiar with grade, you know, you should familiarize yourself and certainly reach out to me or others who have familiarity with this on the staff and committee side too. I just get clarification in your mind. So I just think and just wanted to emphasize this for the group and if you talked about this, forgive me, but this is really been a big enhancement over the past three to four years with NQF's process, so endorsing measures.

Angela Franklin: That's exactly right, Don. And we'll also provide – you know, we provide some support to you, especially the newer members in the form of the committee guidebook which contains a great deal of information but we also are summarizing some of these issues for you for each measure just to kind of give you some key points to start with about what's in the measure form. And then we also will have our workgroup discussion that's report that steering committees can use that time to really get in to the details and have a discussion on themselves about measures. And we'll break the measures up into chunks to accomplish that.

So any other any questions about the systematic review the, body of evidence? OK. We also asked about the time range of the body of evidence to assess currency and that's something that again, if steering committee members are aware of more recent studies, more recent evidence, that should also be brought to the table by the steering committee.

Don Casey: And Angela, we can also – if there is concern about the quality and strength of evidence, we can also feedback to the measured developer for additional evaluation in the process of what we're doing.

Angela Franklin: Yes, we definitely can do that and here's where the process has changed just a bit. Our timeline that we required developers to get back us with information would be extremely short like within days we would – if that were the case it would be within days because we have to have all the information before the in-person meeting. So we still do that. The timing is very short. And we just are testing it out but we're not sure how much leeway we'll be able to get

developers to get back to a specialist who has a major piece of information that we'll have to work or get back to it.

Don Casey: Well, and the other point s if we pass it, we pass it. But if we don't we can get guidance to the measure developer in terms of future reference in terms of how to strengthen the approach to getting the measure endorsed in the future.

Angela Franklin: That's exactly right. So I' guess we'll move on to quantity, quality, and consistency and that's 1A75. And here is – there we go. Here's where NQF asked developers to specifically lay out their quantity, equality, and consistency of evidence cease to support the measure. And what we've want to see here is the robust description of the evidence on which the developers are basing their performance measure. There are some examples of what good look rights like regarding evidence provided are with and there's links in the guidebook I believe as well.

And we'll also provide that to you prior to your review. So here we have what the developers provided. And in the Bernstein review, most were observational work performance single facilities while the(inaudible) review, include original research, peer reviewed commentaries and consensus conference proceeding.

The developer says that the said equality was modest. And there were no randomized control trials but NQF doesn't require these as you'll see it when we turn to the algorithm we put together to help you review these measures. There are no estimates of benefit provided by the developer and there is no assessment of harm. The huge steering committee might ask for clarification, for example, this is a good example from the developer. And the evidence was identified by environmental scan.

So again the steering committee will have to assess with some input from staff the quality of this evidence presented. So moving on to 1A82 where we have more information about the citation and a summary for each piece of evidence. Specific information has been provided along with citations. And again, this will need to be evaluated by the steering committee. And we'll provide you some guidance there.

So taking what you have before you, the steering committee members would then have to review our first algorithm related to evaluating evidence. And then follow the pathways as we described on our orientation call. So just for your reference, this algorithm – our first algorithm is on page 38 of the committee guidebook. I don't think we'll walk through this but we walk through this on the orientation so I won't – I'll spare walking through it but this will help you with arriving at your rating of this evidence with measure.

In addition, remember please that this is an all or none kind of assessment. Again, we expect you'd use your background and your judgment in arriving at a particular rating. So some questions, I'll pause here and say that there are some questions just looking at this evidence that may come to the front for the committee members and that is the evidence presented directly applicable to the process of care being measured, is the process of care proximal and closely related to the desired outcome?

The committee can also consider an exception to the evidence criterion by asking a couple of questions. And we've outlined those on the algorithm. But the committee should also understand that for an exception to be considered, the steering committee as a whole will have to agree that it's acceptable or beneficial to the whole providers accountable without empiric evidence demonstrated to support the measure.

And that …

Don Casey: So, Angela, this is Don. And here is where the committee should go back to my opening statement about thinking about care coordination, you know, as a tension here. So I think the measure steward has provided some elegant albeit rather low quality of evidence supporting the measure although anyone who's been in ED would say, you know, "Get me out of here."

And there's some reason – the reasonable valid points here to make in terms of your deliberation. So for example, getting – if you look at the third bullet, the prolonged ED state around non-ST elevation MI is being evidenced to support this.

The committee should back away as well from this and think about through their own experience, especially if they work in the hospital, some of the strengths obviously but some of the challenges for example of not, you know, and we've all had this experience in hospitals.

The handoff between the ED and the receiving unit, in this case a critical care unit, spelled out so that, you know, if all time – if time is all we're thinking about and the patient bumps up to the ICU and the nurse is there and the treating physicians don't have a clear understanding of what the plan of care has been and what it should be then we may be cutting off our nose to spat our face.

So again, this is not to get into the discussion about this measure but to guide you in terms of thinking critically about not just what's presented but through your own experiences, what some of the counterbalancing arguments might be in terms of thinking about this measure for endorsement.

Ellen Schultz: This is Ellen Schultz from Stanford. I also want to kind of resist the urge to dive into the details of this measure but I have the thought as we go along through this but I feel like there might be some discussion we should have together at the committee maybe before we dive into the details of each of these measure to think about sort of what we consider to be in scope or out of scope.

I mean my sense is that these measures were submitted by measure developer himself but these are measures of care coordination. But there's a lot of debate about really what care coordination is to have interest in it. So I think there's an inclination for people to say, "Yes, this can be a measure of care coordination. Let's put it forward."

So I expect that because we are different groups we may all have a little different interpretation of, you know, is this, you know – if on particular measure – is it getting a good coordination processes either the outcome that will be closely linked to those, or it's measuring coordination process itself, or is there really an aspect of good care and good care includes coordination but maybe that link isn't as strong as we feel like it should be?

And so I mean there are kind of two ways you could go at it. We could, you know, divide this up and I'll have our take on it and then come together and maybe realize when we come together we're not on the same page and have a debate there or perhaps we can have a little bit of discussion up front before we dive in and then sort of come back and compare.

So I'd be really interested, you know, as I work through these measures to think about other people's perspective of what really is good coordination and what is some other aspect of good care or maybe just to make that compelling enough to mash in with coordination processes to think of it as a care coordination measure.

Richard Antonelli: Ellen, this is Rich Antonelli. I absolutely want to second that. And in fact when I first had the opportunity to work with (Jerry Lehman), with Don Casey as co-chairs of the steering committee, Don, I'm sort of reflecting back, we spent a whole lot of time just trying to unconflate that notion of appropriate care versus care coordination.

And I'm going to use that as an example. So if one of the folks on this – on the phone call was this measure developer, I'm not aware of that and forgive me but we had a call for measures. And I remember one of the candidate measures of care coordination was within blank period of time of acute onset of chest pain thought to be a myocardial infarction an aspirin needs to be administered. And at that time, that was considered a care coordination measure.

So I think the definitional piece is absolutely essential if we collectively as a committee and the NQF in particular being responsive to some of the challenges of the map with measure gap filling strategies if we're going to be successful. So thank you for raising that. I was in a queue for that but I'm glad you said it first.

Don Casey: So Ellen, this is …

Ellen: Well, now I think we're not ….

Don Casey: Go ahead.

(Terry O'Malley): This is (Terry). I was just thinking that it almost – if I take your comment correctly, it's almost like we need a question before the set questions, the must pass questions and that is this relevant to care coordination and then call the committee on that piece because there's a wide divergence on that and we're never going to get to the must pass issues for the measure or is that not the process?

Don Casey: No. So (Joe), and Ellen, and Rich – and Rich, thank you for the historic context because this debate has been occurring for several years. I'm sorry (Jerry) isn't on but he's confirmed this. And I think, Ellen, you hit an important point.

What I would advise is that one thing we've worked hard on over the past several years is to sort of, within NQF, be a little clearer on the domains of care coordination and we codified that I think with the preferred practice statements. But, you know, I know we've worked on that since then, so refreshing your memory about those with the useful homework if you haven't.

And then the second part of it is that I think we're going to have to be more in the moment. So they'll be – you know, and Angela, forgive me if I don't get it precisely correct but there'll be some homework for each of you in terms of either individually or as a group reviewing measures before we get into the bit to discuss this. And I think that it probably is at that time in those early discussions where you would try to get at those specific questions that'd been raised.

You know, I think in the interest of time we have to take what we can get in terms of understanding the notion of care coordination which as, you know, as very complex and a bit amorphous depending on how you look at it. So I think we can have the discussion and the debate at the intermediate step. And then if it needs larger vetting, we can get into it. But, you know, all told, what we are challenged with is that there are no perfect measures of care coordination nor are there comprehensive measures. So we have to look at this as the third – what I would call building blocks to get there.

So sometimes we get too perfectionist thinking we might but that must be perfect again. We had a good year. So it's not answering the question directly, Ellen, but it is trying to get tuned to the mindset of just using that thought process throughout the whole step here because there will be two to three chances to sort of get at that question that you've raised through the process.

Angela Franklin: That's correct. And thanks, Don. That reminds me, if we can circulate the previous report which includes the preferred practices if we haven't done that already, we'll make sure the steering committee has that for some context. And you're absolutely right about the homework. The homework occurs in our workgroup or prior to our workgroup meeting. And I would just urge everyone to come prepared to discuss at the workgroup meeting these issues. And then, we can arrive at, you know, some cogent points to bring to the full group at the in-person meeting.

(Kobe Birch): This is (Kobe), if I could just have a question?

Angela Franklin: Yes.

(Kobe Birch): Yes. When I'm looking at this, I didn't know they were not dealing with this but from a procedural perspective – and I appreciate everyone's input and kind of guidance as to how we should think about this – but the perspective, I mean in my brain, I've been an ED nurse. I've been in a critical – director of critical care and acute care director of nursing and now a vice president of a community-based care coordination organization.

So I see the implications of all of these. So when I'm looking at a measure and like we previously was exampled, there are opportunities to consider the implications of all of the things that go along with, for example, this measure. But at the same time when we look down – so if I'm considering, you know, even just the first blush at a situation and say that we – at a measure – and say that we have, this is beyond the place of defining what care coordination is.

When I begin to delve into this, I mean when do we start fettering out? You know, are we talking about pushing people out of the ED's of the community or up to the Med Search unit for a non-ST elevation MI or are we going to the

ICU. I mean when a measure does not really direct us that place and obviously, this is very antiquated ED throughput. This is when ED throughput came about 2006, 2007, 2008, 2009. So this is very old data. I mean it's old studies, you know.

And so, I'm wondering how do you advise us to – what respect should we assume if the measure does not define it for us? Like, where are the measures taking us? You know, the intention of the measure is it looking at only the patient who is going to the ICU or is it the person discharging in the community because it was a measure for the whole ED then, there are going to be people that are going to go to Med Search, going to go home, going to go to the ICU, you know, all of that. You know, when do we begin to fetter out all of the intricacies of those consideration?

Don Casey: (Kobe), I would say those are in the workgroups. And I think having, you know, your expertise in the initial phases of the discussion to bring that point of view to bear would be sort of the right time to get this in to plan. You know, my only point here was not to discredit any of the evidence for citations that have been here but to the extent that we have expertise like yourself put into play, you know, your perspective as an expert on this issue.

So, you know, I think the answer is early on. And trying to create a counterbalancing tension between the lack of clarity in which there will be – you know, you should just expect it to this whole process you will have lack of clarity, you know, and try to do the best you can to sort of frame this up so that when we get to the committee and we're discussing it that, you know, these things are sort of been fleshed out, perhaps even set back to measure steward for response so we can get to the next step of making decisions.

Does that make sense?

(Kobe Birch): No. It does. I appreciate – I was wondering when we get to that place of that level of discussion. OK.

Angela Franklin: Yes. That's exactly right. And I'd also say that formulate these questions, you know, for feeding back to the developer as Don said to try and tease out how, you know, the measure might look differently or what the unintended

consequences of measure are because that's all good information for the developer as well.

(Kobe Birch): Thank you.

Angela Franklin: So – OK. Let's scroll down a bit. That moves us on to our performance gap criterion. And that's section B back on the main form. And right under here the developers provided a lot of information for us explaining the rationale for the measure. And again, we saw the rationale is producing the time patients remaining in the EDs expected to improve access to treatment specific to patient condition.

The developer also provides a good deal of performance score information and one big too. They provide these information both here on the form and they also have attached an attachment which graphically illustrates performance on the measure. We don't need to flash it up right now but the developer finds that the national meeting times for tested hospitals are showing performance in the 10th percentile at about three hours of care. That's 175 to 179 minutes over five. And the testing was done or the testing was done over five quarters beginning in 2012, has little to no improvement shown. And national meeting times during the four and five hour range with little or no improvement over five quarters.

So the committee would have to use that to analyze whether a performance gap has been demonstrated. And scrolling on down to 1B4, the developer did provide an analysis of disparity for this measure. And that analysis is also developed graphically in an attachment and they do show there's little or no disparity in treatment among specific rates for ethnicity.

This is a type of analysis we want which is both numbers and descriptions in a measure. Let's see here. And then this case the developer did provide us information. However, if no information had been provided in this disparity section again, we'd want the steering committee to pipe up if they knew there was information out there that should be cited.

So questions here for the committee could be whether this measure either had a disparities information, additional disparities information or whether this

measure needs to be stratified for disparities. So those are two questions that could be raised there.

Any questions about the gap criterion? OK. That would then move us on to 1C criterion in assessing this must pass criteria. And this is high priority. We formally refer to this as whether to have a high impact on care. So moving down to 1C1, the developer indicates the measure affects large numbers. It affects high resource use in patient, if we have patients with suicidal consequences.

Here in numbers in 1C3, numbers and data are presented with an explanation of the high priority area which is what we want to see in submissions. And for all submissions, the steering committee will need to also assess how related the information provided in the section is to the measure focus. And that is whether a strong link to support the focuses of the measure has been demonstrated.

So in this case that would be a question of whether it's been demonstrated that capturing median time from ED arrival to ED departure for a minute patients was shown to address the problem. So in citation section, we see several citations. And here the staff would do a little bit of homework for the committee and do a quick review that the citation supports the statement above and provide that information to the steering committee for their review.

So that's going down a bit more. There is the citation. And this is not a pro-CRO measure. So at the end of the day, here we're seeking a brief summary of the impact data. And a possible question that the steering committee might ask is whether the committee – I mean whether the measure indeed addresses a significant health problem in terms of high prevalence, high severity and high cost.

Are there any questions before we move away from evidence? No questions? OK.

So this – hearing none, we'll move on to our second must pass criteria, scientific acceptability. So section one of this paragraph form, we're seeking information about the steps and crosscutting areas here just to – appropriate to

our last discussion care coordination is indicated at the crosscutting area. This is not an E-measure so we don't have to do that evaluation.

The developer has provided in an attachment of a table of codes. And steering committee members should review those codes and let us know if they are appropriate to support the measure. I don't have the codes set but I don't think we need to go to that. So in section S3, scrolling on down, this is where we want to see for maintenance measures any changes since the last endorsement. And here we learned the stratification of the measures changed and the developer does provide us good explanation of why. This is definitely what we want to see here in the form.

In this part of the measure, scrolling on down, we also focus on the numerator details and the denominator details. With special attention paid to the data elements presented as well as the denominator exclusions, details, and rationales. And the steering committee should also let us know in their judgment whether the exclusion's being true. Here there's only one exclusion that would factor into analysis.

The developers also provided significant details in these areas as well as – let me scroll down, stratification, stratification details. Specifics about the calculation of the measure, so we'll scroll on through the code, and specifics about how the measure should be calculated as well as sampling methods and how the missing data is handled. We want to see all of this. So this is what we like to see once we get through the code. This is what we like to see inputted into the measure.

Submission form, again, it still has to be assessed. So having information there is half the battle, assessing the quality of it is the second part of the battle. So let's go pass the detailed list and you could see the risk and the algorithm to calculate the measure. And that is all good. So I need to go on down.

Don Casey: Hey, Angela can I just jump in here?

Angela Franklin: Yes, Don.

Don Casey: So again, this is a lot of stuff for us to chew on. There's obviously a lot of detail here. And I bet this has been well thought through previously as a result of thinking about, you know, if this gets used for example for some sort of accountability purpose that places, as I'll call them that, spend more time and effort treating a lot more patients with behavioral health issues, for example, would likely, you know, have their results skewed quite a bit. And make it hence unfair to compare with those who don't have heavy behavioral intercity health type patients.

And, you know, the example on my previous life was Bellevue versus NYU ED, right, where all the behavioral health codes pretty much close to Bellevue. So, you know, I think thinking through in your early discussion, some of these environmental questions could be interesting, for example, you might want to question whether it now perhaps makes sense in order to look at differences between ED effectiveness to include the behavioral health codes. I just made that up.

And the other thing here is, you know, the impact of observation recently in the two-midnight rule has obviously created some new challenges in terms of the precision that's measured compared to prior periods where this wasn't as much of an issue. And I think I saw in the scroll that – and you mentioned Angela that, you know, of the time would – it looks like would be rolled in here. So if I didn't see that right, forgive me, but, you know, these are the types of things for you to be critically spending time on as you go through all these details because these measures are all going to have this type of detail in them if you haven't been through this before.

So it's a chance again for you to identify early questions, to give feedback to the measure steward, to ask for additional information if it's available on a timely fashion, and ultimately, help us to get to the question of is this a measure for endorsement and does it get at what we're trying to get at with care coordination as best as possible. So just framing this a little bit more because it is going to be important for you to look at these details.

Angela Franklin: Correct. Thank you, Don. All right. Any questions before we move on to reliability testing and validity testing? OK.

So now we will have to again refer to an attachment on testing another critical element of these measures. Yes. And so, the top of the instructions are we're looking to see whether data elements are clearly defined, what codes are included and all definitions. And what we mean by testing is that measures must be tested for all the data sources and levels of analysis they have specified in measures. So you want to compare the testing back to the fund of the form as they indicated the levels of analysis.

So here, let's go on that – this is the attachment. Let's go on down to reliability testing. In this case, no reliability testing is presented by the developer and they correctly state that since all critical data elements are validity tested, reliability test is not needed here. So we'll scroll on to reliability and get to the validity sections where testing for this measure was conducted at the data element level. And here we want to be sure that all the critical data elements have been tested.

So that would an assessment that the steering committee needs to make. The actual testing data for this one is not provided here in this section but it's actually grouped at the end of the document if you just scroll down to end of document which can make it a little bit of exercise for committee members to go back and try and compare. What they've done, in this case once again, the staff will summarize and identify the areas, categorize the testing for you to help you through this process.

But just, for our review today, the validity testing presented will have to be evaluated. And here we're looking at – like I said whether there is data for the committee to assess and a lot of explanations have been provided with the Kappa scores which we – in the statistics which we expect to see and want to see. And it's also been calculated using the interclass correlation coefficient which we like to see. And then we will provide – they provide results. And we will provide to you from the staff perspective a bit of an analysis of these results as to whether they followed unacceptable ranges. And this information is also included in your committee guidebook to some extent. Our evaluation would be specific of course to this measure.

Let's see here. Additional assist or questions for the committee here. Again, the assessment whether the data elements really are clearly identified and clearly tested. And we'd have you look to algorithm number three in the committee guidebook to make your assessment. And that's on page 52 of your committee guidebook.

The ultimate question in using a judgment to arrive at a rating and the testing presented is whether this measure identifies meaningful differences about quality based on the focus of measure that's been presented by the developer. And again, this is not all in one discussion. And we expect the committee to bring your background to bear for each of the topical measures.

Again, this is our second must pass criteria. And if this criterion is not met, we're not as meaningful. And, Don, did you have comments here?

Don Casey: No, because I know (Jerry) spent some time in the last call on validity. And I think the – I assume the committee is tuned into this. But these are really critical points here.

Angela Franklin: OK. So moving back to the main form, we'll look at the next criteria around feasibility and usability. And most of our measures are maintenance measure. So this will be an interesting review because they should show that the measures have been feasible to collect with a little bit of historical background for us. So turning to feasibility 3A1, these are data element that are abstracted from record – I'm sorry – abstracted from the record by someone other than the person who obtained the original information.

So that may have to assess, you know, how burdensome this will be for our hospitals to do. There are however the fact that these data elements are extractable from field and a variety of electronic forces. And turn to 3C, the data collection strategy, base here provided to history I referred to we're they've – what they've learned based on having the measure in use. And they're given a description of how they've learned that specks have to be modified every six months according to feedback we've received from clinicians.

Data is available in the medical record and they haven't identified any implementation issue. We talked about missing data a little bit earlier. And they feel like missing data does not impair the integrity of their data result. So that was a topic for discussion for steering committee members, if they feel like this rings true or not.

Moving down to usability and use, these measures are currently in use in federal programs. So that generally would be, you know, that generally would be a deciding factor in whether these are really useful or useable measures And so, these are impacted or in use in CMS and accreditation programs with the joint commission as well some quality and benchmarking programs. And all that information's been provided.

So we also turn to improvement, progress toward our goal, lesson 4B – going down a bit. And I think we discussed earlier the trends showing the last five quarters of available data. And they're noting that the uptick in times might reflect the increasing ED volume. And we also see that they need to determine whether times – whether times decreased in small volume EDs compared to large volume EDs. And some stratification's been requested.

So basically, there hasn't been improvement on this dimension of the measure. And that is something that should be discussed by the committee. The developer does address different ways that they might look at constructing the measure but this is also an area where we'd like to have the committee have a discussion about progress on improvement and what it means.

In 4C we discussed unintended consequences a little bit earlier and this is where some of the concerns and questions that we discussed earlier with the – up for discussion, especially at the workgroup level so that we could bring it to the full steering committee for full steering committee at our full committee meeting.

Are there any questions about feasibility and usability?

Russell Leftwich: This is Russ Leftwich. You mentioned that workflow of getting the required data and the possibility that would be in electronic systems. And so,

obviously, there is going to be a dichotomy between organizations where there is an electronic system or there isn't.

Angela Franklin: Right.

Russell Leftwich: Is there any guidance on how we use this reality to ultimately decide on feasibility? I mean if it's only feasible in electronic systems (inaudible).

Angela Franklin: Go on. So there is no specific guidance to that specific point except that we recognize. There isn't – this is really an area where we want the steering committee to weigh in and provide their judgment.

Don Casey: So Russ, this is Don. I think again, you know, I did a great job previously by bringing your expertise around sort of this big moving gum ball of health IT implementation. And obviously, you've identified a critical variable that would contribute to big differences in terms of how well ED has performed relative to how well, for example, they've implemented electronic systems that improve communication across boundaries.

And I think in the discussion noting that there is this variation but they were all sort of on the same trajectory, some (faster) than others would be useful, you know, whether that could translate into some sort of meaningful risk adjustment that could be measured, I would leave that up to use but, you know, these are the types of things where we just to have to again take the environment for where it is and think about where it's been and where it's going in our own experience and in our own expectations and sort of help this measure, in this case, move along because you're right there's going to be wide variation here. So, you know, that could be a question or that could be a concern that just gets reflected in our discussion as we deliberate.

Is that helpful, Russ?

Russell Leftwich: Yes. Thanks. I'm sorry, I was back on mute. Thanks.

Angela Franklin: All right. Any other comments? So if each of the criteria are met by the measure, we'd move on to checking to see if there are related measures. And in this case there are related measures in the portfolio developed by the same

developer and for review by this committee during the phase. And these are the measures 495 as I said earlier and 497. 495 is total time in ED, 497 is time in ED after the decision to admit.

We'd asked the developer whether all the elements are harmonized and whether they need to be. In this case there probably are not issues of harmonization. But in other cases where there are varying developers, where there are measures that are not in this phase, we've reached out to those developers and asked them to submit their reasons if the measures were not harmonized, why they're not harmonized and whether they can be, and to provide the committee with some input as to how the measures might be harmonized.

We did not relate – we did not find any measures in the portfolios that are competing with the measures in this project which is a different pathway. So are there questions about that process?

I'd also say that this information would be provided to the steering committee ahead of the full steering committee meeting for your evaluation. Yes?

Don Casey: And Angela, just to remind the committee again if you forgot, you know, one of the challenges is that, you know, look up and go, we have way too many measure. So thinking critically about how we can move towards harmonization is really the intent here. And to some extent, you know, that could potentially mean that we send – you know, let's make it up because we have this at the previous steering committee to measure stewards that had very important measures but from which the committee felt was important for them to sort of sit in the room and hammer out coming to agreement on one measure which is not necessarily to say that we must do that because, you know, some measures complement each other.

But here you're really sort of thinking critically about how else you think related measures or grading measure can be harmonized to the extent they can with the hope that we would improve our parsimony, if that's a word, for the future so that there isn't as much confusion with the use of measures that could come together. So …

Angela Franklin: OK. So thank you, Don. That was very helpful. So this concludes kind of us looking at a measure but given the rich discussion thus far, I want throw the floor open for discussion as we've gone through this measure about any questions or concerns to the process, any additional discussion. Hearing none …

(Crosstalk)

Don Casey: May I ask the group if – yes, I'm sorry. Go ahead. Sorry.

(Alison Stanford): OK. This is (Alison Stanford). So I guess one thing that served a little bit more of a global question in my mind is for the tension between note taking what's there and looking into that and deciding was it useful in its current state or is it really not quite there yet?

First it's like going back to developers who are marking recommendations working any additional information. I mean I think that we can go back to my question things but also there is very limited time and that, you know, if we were suggesting changes and such that probably that wouldn't go through.

I just wondered if you have any further comments on that and maybe some past experiences about kind of navigating that tension and not letting desire committee suggestions to get further information toward on the success too much.

Ellen Schultz: Excellent question. And I'll take it by that and let Don also give his experience but what we have to look at is the measure that before as specified for the most part. Unless there are issues that can be addressed by the developer that are not – that don't change the specification because they wouldn't have testing before that change the measure. We wouldn't want to – we could only go back to them for a certain kind of finite changes to the measure. And again, there's a timeliness sector.

The other thing that happened in the past is that in some cases we've asked for testing, additional testing where the developer has had the testing for example or has had additional evidence that they could procure quickly to support the measure and that's worked out in the past.

Again, with our new timelines it might be more difficult. But again the focus is on the measure before you as specified.

Don Casey: That's right, Ellen, we're not in the measure development sphere here. We're in the measurement endorsements sphere. So that's why the quick turn around and I think in the end we're just going to have when the time comes deliberate and use the best decision making that our experts on this committee have to really make a decision. We know that being said for the newer measures I think Angela as I recall time limited endorsement still in play, am I right?

Angela Franklin: No, it's not. There is a tiny, tiny exception but …

Don Casey: Yes, well then forget that because that used to be in play which, you know, for history purposes which we're not going to deal with this time would be for the measure developer to have an endorsement or the expectation at a very finite and relatively short period of time. They would be required to provide more evidence, more validity testing et cetera, et cetera, to help move this measure forward because there are circumstances where, you know, you just want to sort of get off the edge of your chair, you're so excited about this measure but, you know, it's not quite there.

So I don't think we're going to have that opportunity here but it's still important to give feedback and, you know, again not making the perfect enemy and the good as the key here and really keeping your eye in the price is care coordination. So, you know, there's going to – you're just going to be some uncertain hero with using your judgment and, you know, we're going to learn, as do this, you've ever done it. You'll get better at it and you just go through.

Usually, the first one is the longest and then after that we get used to it and we get in the cycle, we get used to each other as a group. We get to know each other's perspectives. So, you know, I think it hits this initial (norming), storming, informing that you'll have to go through to sort of get a rhythm.

Ellen Schultz: I would also just add that in thinking about this a little bit more. We have in the past had those times when the committee was on edge of the seat, excited

about the measure and what they did was provide in the their final report ways and suggestions for the developer to maybe specify the measure differently, construct the measure differently in the future. So they did provide some guidance that could be helpful and there's opportunity of course to bring the measures back.

At this time we're not sure what the timelines are in a later phase. Does that help?

(Alison Stanford): Yes, it does, thank you.

Ellen Schultz: Any other questions?

Don Casey: Well Ellen, having been through this a few times and you're probably have to, it's OK to feel a little queasy at this point about this.

Ellen Schultz: Yes, this is all very (inaudible). Any other comments? So I guess I do want to talk about next step at this point, do you mind, OK. So there we'll pick it through our next step.

Female: So in terms of the next step we have two workgroup call set up for Friday, February 21st and Wednesday, February 26 and they're both at the same time, 2:00 to 4:00 p.m. and we'll be sending you guys an e-mail breaking you up into the two workgroups. And that will probably sometimes in the upcoming week or so. And from there then we will decide what additional calls there will be after that.

Female: That's correct.

Female: So …

Female: Go on. Questions about next step, comments?

(Brenda Lee): Just a comment, this is (Brenda Lee). I just want to extend my appreciation for your walking through this. Because this is such an important undertaking that we're going to be involved in and I will be doing my homework to prepare for this. So thank you for that.

Don Casey: Well, (Brenda), you know, if there's any point in time you feel stuck either reach out to staff and/or (Jerry) and I and, you know, let's have a conversation and that can either be by e-mail or phone. I can remember awhile back getting on the phone for an hour and a half with one of the committee members because he was very concern about a number of things and actually it turned up that, you know, he was nervous because he was representing a certain group and he wanted to be sure he was representing the group.

And so, you know, I was able to talk him down off the ledge because I knew the group and, you know, it didn't necessarily make until perfectly comfortable but at least he felt like he was representing his group correctly and also being a good steward towards NQF. And I think that's – if there is I can say anything about where you both said, where you all said, it's got to be balancing between the expertise that you bring to the table on behalf of you organization and sort of the price that we need to, you know, achieve for the American Health Systems.

So, you know, we're here as resources and we certainly also look forward to any insights you have passed our discussion formally and informally and we'll get to know each other. I know quite a few people that had been on this several iterations and they're all very thoughtful people as I know you are so this is a real opportunity for us to develop a collegial spirit which, you know, is our goal too.

Female: Well with that, if there are no other comments or questions I think we can give you some time back in your days but we want this to be kind of informal gathering so if there are any other questions, let us know. Again staff is always available questions and as Don said yes, if you have you have questions about the homework, please let us know. We'll try to provide as much support for you also through our staff summaries and through the committee guidebook. Do I hear a comment?

Female: I just wanted to add if you can't remember any of our names or have those e-mails the care coordination project mail box is monitored multiple times a day. So we are responding to e-mails and any questions that way as well.

Male: Angela, are you going to just review the timeline again for our next steps? I know you've done that a couple of times but could you just at least for my expectation tell us what the calendar looks like over the next couple months.

Angela Franklin: For the workgroup call we have that information. The workgroup call is scheduled for February 21st and February 26th from 2:00 to 400 p.m. at the same time. And that's right, February 19 was taken off the calendar, sorry. And then our full committee meeting is expected to happen March 18th to 19th and we'll be getting much more details to you about that in February.

Male: Do you have any advice if people in the workgroups for some reason have conflicts and can't make them about sort of the process of feeding in and then feeding back, I don't know if your thoughts are good or not but I know we all get busy and some people can only do part of this and we hate to have you be completely disconnected if it turns out you've got a major conflict or a competing priority so …

Angela Franklin: Right well, we have …

Male: What's your finding on that?

Angela Franklin: Yes, our time is we have really kind of narrowed our focus of the workgroups by grouping them by topics and you can still participate by contacting staff and we walk you through like if we wanted – if you have some comments you want to present at the workgroup call we can do that for you. But we do encourage everyone if at all possible to attend those workgroup meetings that will be broken up by topic so they'll be very topical focus workgroup.

And we are looking for that synergy and discussion amongst the members with the light background in particular. So we hope you'd be able to make it back to us of course and we will walk you through participation.

Female: So I think you mentioned previously that we'll each design one or two measure to work through individually and then take those up to group. Can you talk a little bit about the timing of like when do we do that individual review and then bring it to the workgroup and kind of that, the piece that goes between the actual scheduled calls?

Angela Franklin: Yes, very good. We hope to have a feedback close the business on February 7th your assigned measures. We'll be doing that work next week dividing up the measures and assigning people and getting that package to you by the 7th. Overlaying that package would be a summary by staff of each of the measures. And we will expect for you to do your homework between the 7th and our first was on February 21st to be prepared to present your measure to the workgroup.

And when we say present the measure it's really giving your kind of assessment and questions that have been raised through your review with the measure. Kind of teeing up the measure in terms of this is what it's about. This is the steward and then throwing the discussion open to the full committee, I mean the full workgroup for discussion.

So it's mostly making sure that a couple of people on the workgroup and on the full committee as a whole have really dug into the details of each measure. We try to divide up that burden across the steering committee. The full steering committee still has to weigh in on each measure.

Are there any questions about that? That's really a key point.

Don Casey: I just had a question, (Don), did you assign (Jerry) and I the workgroups or are we going to try to sit in on the individual workgroups just as a …

Angela Franklin: We would like it …

Don Casey: … background adviser.

Angela Franklin: Yes, if you could sit on the workgroups as background advisers that would be great.

Don Casey: Good.

Angela Franklin: We've had – I don't – so if that works out for both of you to be on both calls that will be great or if you want to divide them up, that will be great.

Don Casey: OK. I think we're talking with (Lorelei) later, later next week about this and we can go over with them …

Angela Franklin: Yes.

Don Casey: … but I think for the committee members will be there as sort of, you know, helping the workflow as it were because again, if you're new to this you can really get excited and then do a lot of detailed discussions here and we don't want to stifle that but after a while, some of the discussions start repeating themselves and not to stifle the conversation we want to be sure that we become efficient in the process too so. Again, I'm really looking forward to this and I really think we got a fantastic group.

Angela Franklin: Great. OK, if there are no other comments we can – we'll wrap up and please e-mail us if you remember that you have questions or e-mails, the care coordination mail box. We'll get back to you soon as possible and we will be sending out your packages at the end of next week.

Female: Thank you so much.

Female: Thank you.

Female: Thank you.

Male: Thank you.

Female: Thank you.

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

END