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.

Lauralei Dorian: Good afternoon everyone. This is Lauralei Dorian from NQF. (Inaudible). We would like to thank you for calling in today and particularly for those of you who have already submitted surveys on your measures. I just wanted to remind you before we get started that the call is being recorded today and a transcript will be available for anyone to view following the call. We also have a dedicated time for public comments at the end of the call.

Now, I'm going to turn it over to my colleague, (Zehra) who is going to go through roll call just so we know who we have on the line.

(Zehra): Good afternoon. Is Don Casey on the line?

Donald Casey: Present.

(Zehra): Gerri Lamb?

Gerri Lamb: Here.

(Zehra): Dana Alexander?

Male: We don't hear you very well.

(Zehra): Dana Alexander? Rich Antonelli? Jeremy Boal?

Jeremy Boal: Here.

(Zehra): Emilio Carrillo?

Emilio Carrillo: Here.

(Zehra): Pam Foster?

Pam Foster: Here.

(Zehra): Dawn Hohl?

Dawn Hohl: Here.

(Zehra): Emma Kopleff?

Emma Kopleff: Here.

(Zehra): Jennifer Lail?

Jennifer Lail: Here.

(Zehra): Charlie Lakin?

Charlie Lakin: Here.

(Zehra): Brenda Leath?

Brenda Leath: Here.

(Zehra): Jean Malouin?

Jean Malouin: Here.

(Zehra): And Karen Michael? Are there any additional committee members on the line that I haven't – whose name I haven't called?

Richard Antonelli: Hi. Rich Antonelli, just joining.

(Zehra): OK. Thank you, Rich.

(Terry O'Malley): Hi, Terry O'Malley.

(Zehra): Thanks, Terry.

Ellen Schultz: Hi, this is Ellen Schultz. I'm just listening from the other work group.

(Zehra): All right, great. And do we have Jill or anybody else in the University of Minnesota on the call yet?

Jill Klinger: Yes. This is Jill Klinger from the University of Minnesota.

(Zehra): That's great.

Lauralei Dorian: Oh, that's great. Sounds like we have (inaudible). Again, I wanted to thank you for calling. And before we begin our measure evaluation discussion, I would like to give you a couple of brief project updates. The first of which is that due to a number of projects being shifted around in terms of timeline here at NQF, my colleague Wunmi Isijola has joined as a project manager and I'll continue to be working on this project with Wunmi very closely. And I'll let her introduce herself right now.

Male: Can you get closer to your speaker?

Lauralei Dorian: I'm sorry about that.

Wunmi Isijola: Hi, everyone. I'm Wunmi Isijola. As Lauralei mentioned, I look forward to working with the committee. And like she mentioned, we will be in fact working closely together on this. So I look forward to working with everyone. Thank you.

Lauralei Dorian: Thanks. And so the other project update I wanted to give was sort of a two-fold update. The first is – which you may have already noticed is and we did actually mentioned on our first call is that we've received very – we only received one new measure to this project. We actually have very few measures as – in comparison to a number of other NQF projects. So we decided that it would probably not be worthwhile in terms of your time or our

time to just convene you in – for an in-person meeting, for a two-day in-person meeting in April.

And that's important because we'd really do want to meet everybody and have you meet each other, but you are a standing committee and so you'll be working together in the future and we really just wanted to – well, first of all, so we will be having phone calls, webinars in lieu of that in-person meeting. There will be – we're going to determine the sort of length of those phone calls based on how this work group calls go over this week and next. But, for now, as long as you hold March 18th and 19th – I think that those dates should already been in your calendar. Those are the dates that we're going to have the webinars.

So that's just sort of an update of – projects updates that we've decided recently would make some sense. But we, at NQF and your co-chairs, just really wanted to reiterate how committed we are to having this work be truly meaningful and so that it's not just that we have a group together and we have few measure and you have to evaluate these measures that that actually, we wanted to draw connections between all of the work that's going on around care coordination and other areas at NQF because there is a lot of exciting work and we want to use your expertise to inform that work.

And you might remember that on our orientation call, I discussed one other project that's going on, actually out of another department in NQF. My colleague Sarah Lash and I are working on that. And it's another care coordination project that's actually funded through HHS to recommend specific concept for measure development to them, at the end of the day in the area of care coordination.

And it's not sort of your traditional care coordination like in my – we used to in terms of acute care and discharges from hospitals, but they're actually particularly interested in looking at the coordination between primary care in the community and community-based services. And paying particular attention to social determinants of health, of housing, school, behavioral health in particular.

So that committee has convened and they're sort of – the work is half occurring simultaneous to this work. And so, we really want to make sure that you're aware of each other's work and that you can influence the outcome of that work, and we've had internal meetings to discuss how best to achieve to that. And we decided that we would provide you with an exercise and an opportunity for feedback on the framework during the call on – your calls on March 18th and 19th.

So we'll have some dedicated time for that. We'll circulate more details about that project to you but we just really wanted to reiterate. But if you don't want to do this project in isolation to everything else that's occurring and the exciting work that's happening around care coordination.

So, are there any questions about that or just that Don and Gerri want to say anything (inaudible).

Gerri Lamb: This is Gerri. In addition to welcoming you all, really looking forward to this call. I'm really excited to hear what Lauralei was to sharing with us. The collaboration across the committees is I think going to be really integral to the work ahead, so that we have an opportunity not only to review the current measures but to work with other committees to highlight measurement gaps and look at strategies so that we can encourage the submission of new measures and take them through the review process.

So, I applaud that step for Lauralei and I'm really glad to hear about it.

Dana Alexander: Lauralei, hello. Dana Alexander here. I have a question. Are the other committee group that you were just describing that is looking at care coordination, care management more of outside of the hospital walls, is there – what is the name of that group just so in my mind I can keep them differentiated.

Lauralei Dorian: That is called Prioritizing Measure Gaps. And there are actually five sub-topics, one of which is care coordination. So you'll sometimes hear it referred to as a Gap Project but actually a bit more than that. It's not just identifying gap as we some kinds of have done in the test, but identifying the most fertile

ground for measure development with the understanding that that will be funded for future care coordination performance measurement.

Donald Casey: And Dana, this is Don. Just to be clearer because I think it is pretty clear but just to remind you this other group – the Gaps group will not actually be endorsing measures but rather taking to look at our existing frameworks and seeing how we can revitalize, recharge, recast these topics in light that stimulates more thought-provoking activity around measure development as – I think you all known by now, we've had a positive new measures over the past several years for care coordination.

And I always say that's checking the right thing. And so, one of the opportunities that this group will start and that you'll – by virtue of your participation on this committee have a chance to participate in this sort of this recasting as were.

And so, we will look forward to, you know, your involvement knowing that the committee is really the starting point, not the end point. So, don't feel as if you're left out in check. I think lot of the spirit in what we capture in our discussion here we'll carry over, will (in add) Lauralei to the Gaps group as well, so …

Lauralei Dorian: Exactly, yes.

Donald Casey: And what I'd say to is that, you know, having been at this for a while. We really have to succeed in this next go around in stimulating the environment to really rethink measurements care coordination. It's not that what we have this bad, it's just not – it's necessary but not by any mean sufficient. So, we're looking forward to the next several months working with all of you, directly or indirectly on both.

Richard Antonelli: This is Rich Antonelli. Don and Gerri, hi. Great to be back with you guys again. And Lauralei, I'm just wondering, you mentioned this and Don you alluded to this, this paucity measures submission. Do we have a way of capturing systematically or at least qualitatively what, you know, what's the cost of that is that would certainly inform our thinking. And you might say

that that's the work of the other committee and that's going to happen in March, but if there's any gap in the gap filling, I'd like to be aware of it please.

Gerri Lamb: Absolutely, Rich. You probably – I'm sure, because I've known Rich for a good while now. Have your own thoughts about what is contributing. So, consider, you know, any thoughts you have ahead of our discussion in terms of the root causes of this. I'm not sure I can articulate it on this call but we just want to emphasize the overlap of the two groups.

Richard Antonelli: OK. OK.

Donald Casey: No committee member left behind.

Richard Antonelli: Yes. So, could I – forgive me for being dense and this is a question for the chairs of the staff. I'm, you know, defer to your judgment, but I'm just thinking, can you be a little bit more granular about the line of sites between our committee and that other committee. Commenting on the framework, I heard that (piece) but I think that there is very fertile ground in the space between. And there's a reason why there's a paucity of measures submitted. So, I think the more proactive this – our two groups can be engaged, the better.

So I'd like to challenge us not to think that this is sort of a courtesy peak over the shoulder, but that we're all grinding the sausage maker together.

Lauralei Dorian: Right. That's exactly right and that's the way that we're thinking as well. Not yet into details but I think we wanted to hear your evidence on what sort of the level of evidence is needed for good measure and how to balance the feasibility with something that's really ground-breaking. And you know, because the last thing that we want to do in this other work is to recommend these measure concepts that then come to NQF and fail. I mean, that would not be a good outcome at all.

So, I think it's definitely not just the – we're going to talk to about this. It's very much a, you know, circuitous, we want you to influence that group and vice versa.

Angela Franklin: And this is Angela. I also want just note that we are anticipating a really robust exercise at the March steering committee meeting which will include a specific overlap with the gaps work that's going on and you'll be assigned some specific homework to address some issues around measurements and direction for the field from the consensus development process viewpoint. So that would – there would definitely be a lot of overlaps and integrated work between two groups.

Male: OK.

Lauralei Dorian: Well, at this point I would like to hand it over to Angela Franklin who's going to describe some – the purpose of this call and your roles and give you a brief overview of the measures.

Angela Franklin: Great thanks, Lauralei. Welcome again to the call. And I'm Angela Franklin, Senior Director for the project. And today's call is really intended for us as smaller group to have and in-depth discussion about the measures ahead of the full steering committee webinar in March. And really bring to like any specific issues and questions about each measure and events of having some vote and discuss the measures at that larger, more formal call.

We also have measure developers on the call today, so they can respond to any questions you might have at this time. And if the committee has some specific follow up request to the developer, this is an opportunity to voice those now. Also, developers will have the opportunity if they choose to respond with such request or any questions this committee have before, again, that full committee meeting in March.

Please also use this opportunity, committee members, to ask us any question about the criteria or the process. And if there are any questions at the end of our measure discussion today regarding how that full steering committee call is going to be handled, we'll take the opportunity then to address these questions also. You'll also notice, we've sent you or provided you a lot of materials that many of you in our (CDP) process and that includes the steering committee guidebook, the algorithms of course, and the staff review forms. All intended to aid the steering committee and its evaluation. And we'd

appreciate it if you could let us know how those items works for you as our work moves forward.

I also like to set the stage a bit for the specific measures we're going to be reviewing on the call today. As you all know, these are the seven measures that are intended to be (inaudible) together. And just (inaudible) committee, I'd noticed several ways to how this particular measures work together and how they might need to be reported together. (Inaudible) potentially provide the intended results and include patient care coordination.

And we just want to alert you that NQF and the measure developer have had some conversations already about how these measures work separately and how they might work as a unit or composites should the developers start to go in that direction in future version (inaudible).

And also, I like again say that we do have developers on the call to answer your questions about that. But for now, we're asking that the committee review each measure on its own in their current forms. And also note that in reviewing and discussing the measures, you might notice in your guidebooks that there are several possible outcomes for any measure, including finding exceptions for certain criteria in the guidebook.

And we'd also remind every one that the committee does have an opportunity to bring together (inaudible), background, (inaudible) in discussing these measures (inaudible) …

Male: I think we're losing you.

Female: Yes, and we're having trouble hearing, too.

Angela Franklin: Oh, that was weird, OK, and nothing has change, sorry we'll – I just want to remind the committees that we're asking you to bring your investment expertise to review this – the measures and that the things are not always black and white. So really the value add here is the discussion of the committee of these measures.

Can you here us now?

Female: Yes.

Male: Better.

Angela Franklin: OK, good. So finally, just a process point for this call, we're asking that the lead discussant introduce their assigned measures and preview or quickly summarize the initial process for the group as a whole, if possible. And then open the floor for discussion by the group.

And with that, I think I'd like to turn it over to our co-chairs, Don Casey and Gerri Lamb and I think Don wanted to speak first and provide some additional context. Question?

Jill Klinger: Yes. This is Jill Klinger, the measure developer. I just want to know if you want me jump in or if you would like me to hold my comments until like I'm called upon?

Angela Franklin: Well, typically what we have is the committee will discuss and specifically ask the developer to jump in or but if you feel like something is being mischaracterized, please jump in.

Jill Klinger: OK, thank you very much.

Angela Franklin: Thanks, Jill. So, Don I think …

Donald Casey: Great. So I just send a note out to the group just reminding you to make sure that mute your line if you're speaking. And also if you're listening on your computer and the phone, mute one or the other. I suspect the computer because that will eliminate echo so, thanks.

And I would – Jill, since we have a lot to go through and we're going to do each measure one by one, certainly appreciate your input but I would – I think it might best in the interest of time for you to try to save your comments until the end, unless there are questions that we have during our discussion that need your technical expert, would that work for you?

Jill Klinger: That would work just fine. Thank you very much.

Donald Casey: Great. Because we – because sometimes we get lost and then – no aspersion to you but we get lost sometimes where the measure developer has sort of hi-jacked the conversation. And we want to be sure that committee gets its questions but also that we move forward because we have now about an hour and 35 minutes. And my goal as co-chairing Gerri is to see if we can finish on time, so that will be good.

And Gerri, do you have general comments before we dive in.

Gerri Lamb: No. I think you know, I think folks are ready to dive in. One question though, Don is just to check, the primary reviewer is going to give brief description of the summary of their evaluation, I think everyone should assume people have reviewed the measures so that you don't need to repeat everything in the documentation, and then conclusions. And Don is going to go first.

Question though is, I'm thinking that the secondary reviewers should follow the first and then open it up for discussion when is secondary reviewer going to share their perceptions.

Angela Franklin: That's correct. That's correct, Gerri, exactly.

Gerri Lamb: OK, all right. So primary-secondary discussion and then Jill, we'll bring you in when there are questions.

Donald Casey: Great, great good

Jill Klinger: Great, very well.

Donald Casey: Let me just – because I'm more sensitized to this as well, just a housekeeping too. To those who've been the steering committee before in the group discussions before, we actually got to the final consensus development. We use to take a straw poll and we're not going to do that anymore. So we're not voting on anything today. We're simply trying to capture the spirit of the discussion, be sure everyone's on the same page.

The other thing that I would like to do, Lauralei and Angela, if OK with you is, I would like to just as courtesy to the members, first of all, be sure that there are no looming questions about the content on the website that you have a chance to review. And that if anyone has any new information on a conflict of interest for the measures that we're going to discuss today, and/or feels that they should on the basis of this, recues themselves from the discussion. Speak now and I'm only asking for those who have any new information, silence means that you don't, so any new conflicts of interest or need to recues amongst the committee members?

Very good. Lauralei, I am just trying to be sensitive to documenting that so we've got that in place.

And then I will also presume for the purpose of our committee today that you all have extensively familiarized yourself with our standing committee policy, that you reviewed committee guidebook that you have a pretty good understand of the measure evaluation criteria guidance and understanding what good looks like and a general sense on the call. So, we're going to assume that everyone is good with that and these are documents are upon the on the SharePoints

So, with that being the case, I'm going to jump right in to the first measure and I'm going to go through this quickly. But before I do that, we should disclose that Gerri, myself, Angela and Lauralei had a conversation yesterday about this because we're in sort of unique situation with the first workgroup in the sense that University of Minnesota team has presented all seven measures here. So, part of our discussion was how to approach today's call knowing that there will be some overlaps.

So, what we're also asking you to do in your individual measure discussions is to – to the extent possible try to not repeat if there are common issues that come up, for example, one discussion point was around the notion of composite which we'll get into. But for the purpose of today we're going to review each measure separately. And then obviously we can have a discussion at the end. So, that's the process.

So, I'm going to jump right into 0291 which entitled "Administrative Communication" and I would hope that you all have the documents in front of you. This is one of seven measures submitted of course by University of Minnesota and the measure is in essence designed to evaluate the percentage of patients transferred to another healthcare facility whose medical record documentation indicated that administrative information was communicated to the receiving facility within prior departure.

So, I'm going to basically assumed that you read through the details – the brief measure information, the importance to measure and report under that – under the main section of one. And then, under two, we have the validity and reliability information and that is well detailed here. And three as the Feasibility, four, Usability and Use, five, Related and Competing Measures. Here we list out on page nine, the numbers of the other measures we'll be discussing. And then the measure information which starts on page nine which gives you a lot more details that are elegantly provided by University of Minnesota.

So, the way I approach this is to think just generically in terms of the pros and cons of endorsing this measure. And again, this is a measure that is already endorsed so this is a maintenance process. In other words, maintenance means we're going to be when we need in March, deciding whether this measure should continue as an endorsed measure or not. We're not going to decide that today, but let me just start by filling in my pros and cons about the measure itself.

First of all, it's clear that this measure was designed to fill a gap. Part of the challenge with these measures is that they came on a scene at the time when there was a focus on obviously measuring a transitions and (handouts) between a hospitals who provide emergency care and then move patients to another institution.

And the big challenge then was, in summary, that the rural hospitals, and again, I speak more generically to talk about small hospitals because we've been in urban areas where there been small hospitals, but certainly the rural hospitals, especially those for example that no real healthcare facility is close

by, such us critical access hospitals, really do need to get this right. And at the time, they were not intentionally, but unintentionally excluded from the measures because the small numbers that were related to the challenges with measuring.

This has been field-tested, the inter-rater reliability is moderate. Obviously, the importance of transmitting comprehensive information is critical especially when the stakes are high between the smaller rural hospitals and the larger receiving centers. There was a need to allow smaller hospitals to be represented on Hospital Compare.

Anyone who's ever worked in a critical access hospital or worked with people in the critical access hospital knows how proud these folks are of the care they deliver, and to not be represented or have a way to express their excellence, is a shortcoming that this measure preceded to help fill because it's hard work and not receiving credit and documented credit for it is – it doesn't help the morale.

Variation is well documented. In 2006, there was lots of variation in terms of how frequently this was done correct. There was good discussion of this measure is (congruent), for example, the Joint Commission National Patient Safety Goals related to transitional care. And certainly, care transition is necessary, albeit not sufficient, component of care coordination. So those are my high level discussion points around why this is – the pros of considering endorsement.

On the cons, and again these are relative – this is a process measure as defined by the University of Minnesota. There isn't direct linkages to outcomes, although there is an expectation of not having the information at the critical end of the receiving institution is certainly at least potentially contributing to time delays. The small numbers in the samples creates a challenge statistically from using this as a comparator between hospitals as a measure of quality.

As I did point out, this measure is brought in with other measures, so it is not sufficient by itself, although it does address one specific aspect of the

transmission of useful information. I thought that – and I know the measure developer will talk about this because there's new information that the – at least the documentation and the abstraction had not evolved to, for example, the development of an E-measure. The, you know, the congruence with meaningful use of this type of information is obviously evolving much more rapidly than it was, say, eight years ago.

But, you know, I think that meaningful use is a work in progress, too. So, this is, by no means, a deal breaker, but it seems is though, this is a type of information and would land itself to – with appropriate information systems in place, successful transmission.

And there hadn't been at least in the submission form and update in terms of how the evaluation was done. I think the sample was about 1,500 patients. There is explicit mentioned by the measure developers that the details from 2012 and 2013 are not available yet, at least in the time this document was presented. I'm sure we will hear something about that from measure developers, but those are basically my oversight comments on this measure.

And I will turn it over to the secondary reviewer.

Jeremy Boal: Hi. This is Jeremy Boal. You know, I'm …

Gerri Lamb: Jeremy?

Jeremy Boal: … sure. I'm new to the committee, I'm new to the process. And I don't have very much to add. I'm still kind of taking all these in and making sure that I understand how to contribute. I think Don covered this very well.

You know, my own sense is that the pros are significant and the – this measure doesn't fit terribly neatly into the NQF methodology for, you know, determining, you know, whether it should be endorsed or not. I think there's a number of reasons for that, but there isn't a lot of risk associated with this measure and there were significant evidence supporting, you know, the need for transition information. And so, you know, I think that the measure developers have done a very nice job given the challenge of creating a

measure like this. And giving us a road map for potential endorsement or maintenance.

Gerri Lamb: Thanks, Jeremy. I guess, Lauralei and Angela, what we would do with be to then ask for comments and input from the committee.

Female: Yes. That's correct. Go ahead and open the line for discussion.

Gerri Lamb: And please identify yourself, too in the discussion. Thanks.

Karen Michael: This is Karen Michael from AmeriHealth Caritas. I (sort of) understand the few value, I understand the reason behind the measure. My one concern though is that it seems to be very administratively intense. It's not something that's going to be able to collected through any type of the electronic data system than in most part.

So, I mean – another (inaudible) of these measures. So, maybe there's a need to look at when we look at the (measure) say, a total – so how many should go forward given the administrative nature to each of them.

Gerri Lamb: I'd like to follow that up. This Gerri, because I have a similar question to Karen's about the feasibility, and Don and Jeremy, this maybe a place that Jill can help us, it seemed in the documentation that there were multiple sources of data for this measure, and it came from HER, it comes from lab, but it also comes from paper. Can we get a sense of, you know, at least in the test in the 2012-2013, what proportion of it, you know, at least estimated, is coming from electronic sources.

Jill Klinger: This is Jill. And I think this is when I'm suppose to come in?

Gerri Lamb: Sure.

Jill Klinger: We have – just to address a couple of things related to that feasibility. We have done a cross lab with the meaningful use criteria, and I don't have that with me right now but I can definitely send that to the – to the – to Lauralei and then that can be forwarded to the committee. The records – the emergency department records that are being reviewed whether there'd be in

paper or electronic are pretty short. Someone that's being transferred out, generally speaking, we have found has been in the – the department less than four hours. And so the intensity of administrative work is actually not – not that. We have not had complains about that.

The hospitals that we have worked with have not had a problem collecting this data. And as we move to electronic medical records, I do believe that that this measure will become obsolete because as soon as everyone is connected, they will have immediate access to that information. So, I believe that in maybe five or 10 years, this will not be needed.

Donald Casey: Right. So, Jill, thank you for that. And just to remind folks like Jeremy who have not been through this before, part of our interaction with the measure developer is to do precisely what Jill has suggested which is to post questions that may not be answerable in the call today but which the measure steward will then first gather information and filter it back so that you can remember everything. And this is an example of where you will get now additional information from Jill about this measure through the request. So, that's good.

And again, we're talking not about endorsing the measure five years from now. We're talking about endorsing the measure now given that it's been in place since '06. So, other questions, comments on this measure? Thank you, Jill.

Pam Foster: So, this is Pam Foster. I just want to – appreciate the comment about the meaningful use because one of the pieces of meaningful use that will come due this spring is that patient care summary. And so any patient that is transferred to another facility will have to have a record in the EMR as what pieces of health (information) were sent with the patient. So, as we move forward in the near future, that should be pretty easy to abstract.

Gerri Lamb: Yes. So, Pam, that is a good point. And I think the question is not – if it's a matter of when in terms of when we will have the perfect world where everyone is on the same page so that, you know, we're in a sort of an evolutionary process now in terms of the relevance of this measure.

Pam Foster: Correct. And not everybody is participating in a meaningful use, but that is just something to keep in mind as we evaluate the feasibility.

Donald Casey: Exactly. Thank you.

Emma Kopleff: Hi. This is Emma Kopleff from National Partnership for Women and Families. I have a general question for Jill and perhaps the NQF staff as well. And not – and it maybe related to the feasibility issue. But I'm noticing that we don't have a lot of information on the use of this measure since its endorsement initially in 2007, and of course I'm – applied to the rest of the measures in the set. And I guess I would start with asking Jill if she could speak a little bit to why that might be that the measure is not put into use or perhaps we just don't have the right information in front of us.

And then as a follow-up, I would ask the NQF staff to comment how they are handling that as their maintenance processes grow because I heard from colleagues of mine sitting on other committees that that at times has been considered a barrier to endorsement.

Donald Casey: So, Emma, that's a really good point and I think it relates to my comment about how the measure developers mentioned in their presentation that the data that's been collected from '12 and '13, I think it is – was not available at the time this was submitted. So, Jill, do you want to address on this comment?

Jill Klinger: Yes. Thank you for this opportunity. In the state of Minnesota as of January of 2012, requires the submission of this data from all the critical access hospitals. So we do – we have not yet gotten the information from the state and we may not be given access to that data because of privacy concerns to do an analysis.

Additionally, the QIO in Minnesota Stratis Health is on contract now to lead eight more states in the requirements of submission of data on these measures. And that's undergoing submission now that the training was in the fall of last year, I believe, so that they are currently – all of the critical access hospitals from those states are now submitting data.

And in the fall, MBQIP which we see this information from national – from all critical access hospitals, these measures will be implemented at that point for submission to MBQIP and then Hospital Compare. And I can send you the documentations about the Minnesota project and the eight state projects and the MBQIP plan so that you have that additional information.

In the years between 2006 and 2012, additionally, it was used in Washington State as part of a small rural health network. And then additionally, Stroudwater and Stratis Health did another study, I believe it was in 2010, with four more states.

Donald Casey: Thank you. And in – under 2A2 on page five, it is the documentation about the data that's been collected. And so, you know, part of the challenge that the committee will have in March is when we get to – this is a hypothetical situation, Emma, you know, we get to the point where we don't have new information, then that's going to have to factor into your deliberation as to how you vote on this measure for continued endorsement.

Emma Kopleff: Thank you. That's very helpful. And just to clarify and maybe Jill can tell us offline with some of that information which is really helpful, thank you. When you refer to some of the state initiatives that are using the measures, presumably that is for public reporting programs?

Jill Klinger: Yes. In Minnesota, it's for a public reporting program, but unfortunately, because of some of our MNsure reporting requirements, this has been put in the backburner for the reporting team at the state. But for the eight states, I am not sure what the plan is for public reporting, but I believe that that's been part of it including – and also for the MBQIP plan project.

Emma Kopleff: And I apologize, I missed some of that in the form. Thanks.

Donald Casey: And Jill, Don again. Just remind me because I don't have it precise. Your comments that you just made and that we're discussing are I believe applicable to all measures that we're going to discuss today?

Jill Klinger: That is correct.

Donald Casey: Good. So, this would be a generic issue when we get to the other measures. Other questions or comments?

Brenda Leath: Yes. This is Brenda Leath. I have a question for Jill as well. And you may or may not already know this because it relates to the data that you don't have, but was the intent or was there a strategy put in place to collect information about disparities?

Jill Klinger: No. As far as I know, there is no disparity of racial, gender or poverty status collected in any way in this data by any of the field tests or pilot tests or under the activities that are current.

Donald Casey: So, Brenda, I think, as I recall, this was not risk adjusted in that way either. So, you know, one could obviously argue that one potential of healthcare disparity here would be the side of care being in a rural or underserved area, but I didn't see any mention of this nor did I see an intent to risk adjust this measure.

Brenda Leath: I understand because what I'm thinking is that there had been very limited studies done to look at the differences in that way. So, I was just curious whether or not there was any strategy put in place.

Donald Casey: So, Brenda, in your experience though with very small numbers, one question that I would have would be how easy or difficult is it to – with very small numbers then to further sub-stratification risk assessment, I'm just asking.

Brenda Leath: Very – it's challenging. It's very challenging to be able to extrapolate that information and have confidence that that can be informative and generalizable.

Donald Casey: For like public reporting and things like that and accountability?

Brenda Leath: Yes.

Male: Thank you. Great. Other comments?

Jill Klinger: Sorry, this is Jill again. And rural areas have a higher percentage of low income and a higher percentage of the elderly. And depending from the state,

a lower or higher percentage of different racial minorities but, you know, that's all I have. Sorry.

Donald Casey: OK. What I'd like to do is just now see if there are any additional comments. We have six other measures to go through in the next 70 minutes. So, anyone have any other comments or questions at this point?

Gerri Lamb: This is Gerri, Don. Kind of a point of reference here. I think that you and Jeremy did really gave a thorough overview of kind of the big picture and some of the reasons that these measures don't exactly fit the guideline criteria that we were all using. I'm thinking that for kind of keeping, you know, or for having as comprehensive information as we can for the March meeting, that we also need to drill down into those criteria so that we have them on record, not for Jill to respond to each one but to at least raise them as potentials for improvement or some gaps. And I know that I did that for my measure but I was – since these are all the same, should we just hold that until we get to the next measure?

Donald Casey: Yes, I think so, Gerri. And I think your point is well-taken about having that conversation.

If there no other questions or comment at this point – and by way this is not the only time questions or comments are processed. So you'll have a chance to look further but, Lauralei and Angela why don't we move on.

Angela Franklin: Sure. And I will just reiterate, Gerri made a very good a point that we should be speaking specifically to each of the four criteria as we discuss the measures. We're not voting today but we just want to make sure that we've thought about and discuss each of the criteria in turn. And then, Jill offered some very good information that she will provide to us and Jill will talk to you offline about that so that we can make sure that gets to the committee.

Jill Klinger: Great. Thank you very much.

Gerri Lamb: OK. So we move on to the next one then. Measure 292 vital signs. I am primary discussant and Dawn is secondary. So I will start and I'm not going

to repeat anything that we've already discussed or that Don and Jeremy reviewed.

292 is the second in the set of seven patient transfer measures and that the title of this one is "Vitals". And the description is the percentage of patients transferred to another healthcare facility who's medical record documentation indicated that the entire vital signs record was communicated to the receiving facility within 60 minutes of documentation – excuse me 60 minutes of departure.

OK. Like the others this is a process measure and level of analysis is facility, and it was originally endorsed in 2007. There are six data elements or patient care elements within the vital signs measure, pulse, respiratory rate, blood pressure, oxygen set, temperature and the Glasgow when appropriate.

OK and so we have the big picture in terms of importance of ED in the rural areas and transfer of information. And so I'm going to go through the specific four categories of criteria.

First one being importance to measure evidence. The criterion there is whether the measure demonstrates that in fact an improved quality and the sources and the grading of that evidence. For the documentation we have, this evidence is based on a literature review and input from an expert panel. I did not see detail on the literature reviewed.

The lit review that we have at the end of the document has some empirical studies, not a lot. There isn't a lot of information on that systematic lit review. And according to the guidance in the guidelines, expert opinion is not considered empirical evidence.

So, we do not have the grading of the evidence in the lit review and we have statement that it's systematic, but not a lot of additional support for that. In terms of the table for the level of the – or the strength of evidence, I am going through the algorithm. It appeared to me that that was low. And there – we do have in further discussion, particularly in March the ability to create a

exception. This is a must have criterion. Some of the sub-headers under the importance, gaps and care – excuse me.

We have data that suggest that there is a gap in the rural areas but it's not specific to the data elements in 292. And that transfer is more problematic in rural hospitals and not all of the patient care elements are important, again not specific to 292. As was said in the previous measure, we do not have information about the disparities nor whether this is specifically relevant to priority population, although Jill's comment did speak to that.

We're going to move on to scientific acceptability, reliability. The information we have about reliability is inter-rater reliability done through transfer records. Exclusion are specified.

As was mentioned before, there's no risk adjustment. It appears that the measure of inter-rater reliability is simple agreement. And it was not corrected for chance even using common metrics that are in our guide like Cohen's Kappa. The level of agreement was 68 percent to 82 percent moderate, it improved over time. But statistics are not provided for the second field test nor do we have a rater reliability on the specific data elements that we're looking at in this instrument.

Validity, we have information about phase validity and an expert panel, the rating were greater than four on a scale of one to five, rated to usefulness. We do not have other information about the linkage to patient outcomes.

Feasibility we've already discussed in terms of the crosswalk with meaningful use and some of the plans down the road. Similarly we have information that some – there had been some small test in using these data to demonstrate improved quality and that more are planned down the road.

So overall, OK, on the big picture, my evaluation is consistent with what we talked about in the previous when we drill down into the specific criteria importance because of the lack of supporting evidence is low. Several of the criterion are not addressed specifically. Reliability is OK, but it could be

corrected for chance. Validity is at the lowest level, again OK. And feasibility and usability we talked about as evolving.

Dawn?

Female: Well …

Donald Casey: Thanks, Gerri. And – you know, let me just say that thank God that Gerri is co-chair because I tend to be less organized and Gerri did a great job with sticking to the script which is really, you know, what we're going to follow when we get into the room and we actually vote. We're going to these things as we will be voting on, so Gerri thank you for sort of recasting the discussion at the context of your outline which was appropriate.

I don't really have much the answer, you know, obviously the side bar here is that one, perhaps couldn't imagine a patient is coming without this information and quite frankly, without the rest of the information captured in the other measures. And, you know, while we're going to have the discussion right now about the importance of considering this is a composite measure because that's not appropriate for the discussion.

It is probably on everyone's mind, so I would say that I agree fully with Gerri's – with Gerri's assessment and don't really have much else to add.

Gerri Lamb: And Don, before you go, let me just share with the rest of the group. I think we just demonstrated that – exactly what Angela was saying before which is this is not black and white picture, which Don often refers to as not throwing out the baby with the bathwater. And then, you know, we collect the data to really look at the merits of the instrument according to the guidelines. But the decision making that we'll be facing in March as I think we can all see is not straightforward.

So, I think the intent here is to collect all of the discussion, all of the data, and then we can have a thoughtful conversation in March.

Dawn, your comments?

Dawn Hohl: Thank you. Gerri, that was so thorough. The only point that I wanted to add was as we look at the measure was looking at (post acute) is there's a possibility? And I would ask the developer, and I think this will come up later, is there a possibility that this could be expanded to include patients going to other settings including homecare and others, and it might broaden and has more meaning from a real true care coordination perspective.

So, that was a question that came up and that can be deferred to a broader discussion later. But …

Donald Casey: I'm sorry, who was speaking?

Dawn Hohl: Dawn Hohl. I'm the secondary reviewer.

Donald Casey: Dawn. Great, thanks. I'm sorry, I thought you said Don. I'm sorry.

Dawn Hohl: That's OK. That's OK.

Gerri Lamb: But your comments, Don, were very timely and important.

Donald Casey: Sorry.

Gerri Lamb: Let's open it up for discussion. Other comments about 292?

Anybody got any reflections so far in terms of the two – I guess, you know, we're supposed to be looking at these as individual items but clearly, as I said, there's a lot of similarities here. Any comments overall in terms of each of the criteria or the big picture that we've been talking about?

Pam Foster: Gerri, this is Pam Foster and I did have one question, maybe somebody from NQF can help me understand. As I worked through the, you know, trying to evaluate each section and I used the algorithms that were supplied in the initial orientation PowerPoint, I had a difficult time and maybe it was just me working through the reliability algorithm.

And I – so in my evaluation, I couldn't tell whether to rate it as insufficient or moderate based on my application. I kept coming up with insufficient but I

wasn't entirely sure, and so I don't know based just clearly on the algorithm, if somebody could help me understand that.

Angela Franklin: Sure. This is Angela. Don, you said you – I mean, could you kind of walk me through – I'm sorry. Pam Foster …

Pam Foster: Yes.

Angela Franklin: Could you let me know where you had the hang up?

Pam Foster: Well, yes. I think it was because the patient level data was not provided. And so I – if I was following it correctly, it kept leading me to insufficient.

Angela Franklin: And that is the – that is the way the algorithm is supposed to work. If it's something that the developer could speak to or if it's something that we're not seeing that is available from the developer that would change things, but if it's not provided, then it would be in greater …

Pam Foster: OK. That's what I thought, but I wanted to make sure.

Jill Klinger: This is Jill. I'm not familiar with that algorithm, so if that could be provided to me at some point, that would be helpful.

Angela Franklin: Yes. We can send that out to you. We're kind of – we'd flash it up right now on the site, but it's within a larger document and we can send that off to you, Jill. (Inaudible) developer guidebook as well.

Terry O'Malley: Hi. This is Terry O'Malley. Just a question, you know, the six vital sign, pain, I wasn't sure that I saw that anywhere else. I wonder if any thought had been given to that issue.

Jill Klinger: Pain levels? This is Jill. Is that a question for me?

Terry O'Malley: Yes, yes, pain level.

Jill Klinger: No, we don't have that in the measure at all and it is not – it has not been considered, it has not been brought up. So, I'll bring it forth the next time we get together. Thank you.

Emma Kopleff: I would like to push on that. This is Emma Kopleff again. In that, you know, without going down the rabbit hole of suggesting total remakes in the measures, I obviously come from National Partnership for Women and Families and we have a large body of work around patient engagement. So, something that really struck me is both in the development of this measure and in the validity and reliability testing with the use of inter-rater reliability and expert panels.

On paper, it read as if the measure failed to receive upstream input from patient, families, and caregivers. And I think that would be really valuable in terms of identifying things like pain that are really valuable to patients as they act as active partners in managing their care between settings.

Jill Klinger: In terms of providers, we did have rural physicians, rural pharmacists, rural nurses, rural CEOs. So, facility and provider representation, and as you know in most rural areas, if you live there, you're also a patient there. But we have not expanded it to people who are not discharged to a facility. It has been expanded to include all other facility discharges including nursing homes, assisted living, and facility-based hospice.

I think that the information that's needed – the way we had looked at it is that the information that's needed for an individual caregiver who's not a professional medical person is different. And so we don't have that for – with these measures specifically.

Emma Kopleff: Understood and I'd be happy to connect offline. I'd love to share with you a large body of work National Partnership has done speaking to the importance of all quality measures really ultimately serving the needs of patients at the end of the day. Thank you.

Jill Klinger: That will be great. I'd love to have the conversation.

Emma Kopleff: Thanks.

Gerri Lamb: Thank you. Any other comments about the review of 292?

OK. I'm hearing none, we should move into 293. Pam, you are the primary discussant.

Pam Foster: Yes. And this measure title is "Medication Information". And just as the other two measures that we've discussed already very similar. The brief description of this measure is the percentage of patients transferred to another healthcare facility whose medical record documentation indicated that medication information was communicated to the receiving facility within 60 minutes of departure. And the numerator would include documentation regarding medication history, allergies, and then the current medication given or the MAR. And the denominator would be all emergency department patients who are transferred to another healthcare facility.

And so like the other measures, this is a process measure. And I think Gerri did a very good job of summarizing the four areas. And I would say that my summary would be very similar to her in terms of the reliability and the validity concerns. I think we've established the importance to measure and the feasibility and the usability.

You know, I just would like to say, thinking the overall context, medication administration as well as medication history and allergies is a basic standard of care that patient should expect to be transferred with them when they go to another facility. So, I think this is – it does rank high in terms of safety.

And, you know, I think we, you know, we think about this today as – that it routinely happens, but, you know, when there's a medication error, it can be, you know, obviously catastrophic. And so I think this is very important to measure in terms of care coordination.

And I work in – the region that I work in, we have four critical access hospitals that I work with out of PPS hospital. And, you know, I can tell you that this – some of this information doesn't always come with the patient timely. And when it doesn't come timely, it does cause a lot of issues for the patient and for the caregiver.

And so, you know, even though we think in terms of, you know, we have this information typically readily available and we should, there are times, you know, in those settings when that doesn't happen. And so I think it is very important and it is – in the pieces of care coordination, it is – I think it does fit well with that. So, that's just my assessment.

Gerri Lamb: Thanks, Pam. Did you have anything else to add or should we move on to Emma?

Pam Foster: No. Please move on. I don't – unless anyone has any questions.

Jill Klinger: Emma, why don't you give your evaluation and then we can have a discussion.

Emma Kopleff: Sure. Just a comment because Angela had prompted it today at the beginning about the algorithm that NQF staff has provided in their background materials as well as the guidebook. I will say I found those materials extremely helpful, but I know where all the ongoing quality improvement and I think it would be really important to share that information with the developer in the future, earlier could be better. Because for me there is a bit of disconnect here between the input we're providing Jill and her sort of ability to translate based on the specific criteria.

So I know that will be remedied but so in short, things for the algorithms. And I look forward that those continuing to be useful.

I will say in terms of importance, I really sort of struggled similar to Pam's comments are on this is the algorithm for reliability. I got stuck in the algorithm for importance because, sort of the number question asked is the outcome there. And I'm just not convinced based on the information provided and sort of the challenge this measure, I think, is the broad focus. And you know, maybe it would have been helpful given the initial intent around rural hospital or quality improvement. And some of the literature had mirrored that.

Similarly, you know, we as a committee will have to figure out how (rigidly) to apply this criteria because when I look at the need for NQF criteria for systematic review of a body of evidence to support the measure's importance

and things like rating the quantity, quality and consistency and the evidence fairly quite have (this area) and I think others have said something similar. So I look forward to working through that together in the upcoming months.

I think those are my general add-ons similarly in my rating of the other criteria. I had some lower ratings based on some of the information provided. And I mentioned my point about you know, rater reliability. It would have been nice to see some additional analysis on and also perhaps the developer or can clarify for me.

It seems that those analyses were done at the data element level. But then the results presented were aggregated and sort of just generally that all the elements were understood. And I think it might be even helpful to have more the detailed analysis around each elements but NQF staff can also (pick up) if that's not expected.

Angela Franklin: We do ask for information at the data element level which the developer provided, and Jill if you wanted to speak to that as well. I also wanted to go back to your other point about the algorithm and the information that NQF has provided – that NQF has provided to developers the developer guidebook. And early in the process, we can see if we can make that a little bit more, more clear for the developers.

The second thing is on the algorithm, we do ask that the committee members still – still leaves room for committee members to bring their judgment to bear in terms of, for example, the first question in algorithm one, whether do you feel like the process structure help outcome link has been appropriately defined? We ask you to bring your judgment to bear in making that determination and be ready to discuss why or why not you feel you could move on to whichever box.

And we do ask testing be provided as a data element level and I let, Jill respond to the testing question.

Jill Klinger: Yes, this is Jill. We could not do the data element testing at – we didn't – we didn't do inter-rater reliability at the element level. It was more of an

implementation than a scientific research project, and it was summarized in that way. So it was not done at any other levels at the – at the element level.

So I apologized for that, but that's – that's not available. It maybe available for the 2012, 2013 data, I'll have to check with our colleagues on that. So I – I apologized, it wasn't done and that the details have been lost to the snow bank, I'm afraid.

Angela Franklin: No, problem, thanks for clarifying them.

Gerri Lamb: OK, any other comments about – about 293?

Richard Antonelli: Yes, this is Rich Antonelli. I'm sort of looking at this and through the lens as something that's already here which is (Med Rec). And I've just – I've just want to think about the, you know, and feel free to push back if I'm asking something that's a bit out of the scope because well, certainly the measure itself has – has merit and – and this is potentially – the vote in March is going to be around the maintenance, I am just sort of seeking about that, you know, are these elements something that's already there?

Emma Kopleff: Are in another measure you mean?

Richard Antonelli: Yes.

Gerri Lamb: No, I was thinking about that as well, Rich and maybe that would be something we can put under related measures because, while it's in – like you were saying, it's not exactly the same as (Med Rec). It is related to the transfer of information, accurate information around medications.

Richard Antonelli: Yes.

Gerri Lamb: And – and it seemed to me that – that might be a discussion under related measures to – to look at.

Richard Antonelli: Yes.

Terry O'Malley: Hi, this is Terry O'Malley again. The Med – one of the reviewers of the (Med Rec) measure coming up and it – it's like to me that it gets to the issue of how

accurate is the information that's being transmitted. So one important piece is that you got the information, and the second piece is that you get as accurate. And I think the (Med Rec) piece speaks to that latter approach of the measure.

Jennifer Lail: And this is Jennifer Lail. We hadn't identified with 293 as related to the (Med Rec) measure but we can take a better and look at that?

Female: Terrence, with your work with (Med Rec), so am I to understand from your comments that you do see a connect here?

Terry O'Malley: I think, I mean one of the biggest challenge of getting a medication list which is essentially what this measure is proposing just been is that you just – you don't kind of know what the prominence of that list is. You don't know whether it's been reviewed, who reviewed it, how did it compare with what it started with. So there's – it sort of arrived and says, "Here's the medication list." But you don't know where that list came from necessarily.

Richard Antonelli: Yes. And I was sort of thinking about it, Terry, exactly that way. I'm the receiving clinician and I should be getting, you know, that data stream. So, this is coming through and I'm getting something else on the (Med Rec)'s side. And what I'm trying to do is, so Gerri, I think strategically I like the way you framed this as topic for further conversation. But I want to make sure that, you know, data is as informative as possible.

Female: It makes sense.

Pam Foster: I think the specific elements of this 293 measure, the documentation regarding medication history, second allergies, and three medications given, one could really argue that there is a very high likelihood that the patient understands those very basic things.

Ultimately any documentation regarding medication history probably came from them as a source at some point. Others can feel free to offer an alternative perspective on that. But I could see where something like medication reconciliation has more of a negation between the clinical perspective and doc and the patient and could be more valuable in terms of transferring information.

Dana Alexander: This is Dana. This is – I was thinking along with some of the same lines as, you know, if the medication list as generated by what the patient has communicated, you know, in the emergency room to the clinician. That he's not necessarily been validated against truly what the patient is actually taking of is been ordered by the primary care physician or whoever else.

You know, so there – I think there's a lot of potential, I guess, clear holes in this in terms of this medication list and medication reconciliation in terms of how, you know, where is the information coming from and how is it actually being validated.

Donald Casey: So this is Don. I think this is a particularly challenging one. I mean, one could be (curios) about this in the sense that under ideal circumstances relative to Rich's comment, you know, knowing precisely what the patient is on and the dose and when it was last taken and all of that would be ideal. But obviously, especially in the setting of the ED which is quite different than the 2456 measure which is focused on a hospital, this is just about kind of getting high level information at the best as possible in the ED knowing that the ED is a place to do this. But it's kind of like it's a wonderful life question which is what would happen if no one have this information, right?

So, in that sense, you have to, again, balance out the circumstances with the need. So, I would just highlight that as a limitation of the measure. It's not going to be perfect.

Female: Right.

Richard Antonelli: And I think, Don, just sort of punctuation put on this. This is Rich again. So when this comes up for discussion in March, and this is for the measure developers, to the degree that we can do a – pardon the pun, reconciliation which was a (Med Rec) information already is, that would be very, very helpful. This somehow add or compliment to that. The prominent issue that Terry alluded to, I think is so very important.

Jill Klinger: This is Jill speaking. Reconciliation is much more intense requirement and it's very, very important. And we've been paying some attention to that as well

and it's not included in this measure for exactly the emergency department reasons that someone else already mentioned.

Pam Foster: Right. And this is Pam Foster. I think, you know, there is – I'm not sure it's appropriate for this measure, but I think there is an opportunity for some (Med Rec) in the ED, for example, if the ED is transferring a patient to a skilled nursing facility. In that circumstance, we would definitely want to make sure that happens. But if it's, you know, if you're treating a trauma or an MI or something where you've got to just get that patient transferred, there's no time to do that. So I think trying to lump that in with this measure may not really fit but it is an important consideration and maybe worthy of discussion.

Terry O'Malley: Hi, this is Terry again. And so – in the height of ambivalent, you know, having worked in the ED, I entirely in agreement with the fact that the ED is not the place to do medication reconciliation. Maybe this measure just needs to be clearly constrained to say this is what we learned that the patient was on, this is what we gave them. This is what they're getting on route. And leave it at that and let medication reconciliation be a separate process if it's done great but if it's not, then it's almost the next site that has to do the reconciliation.

Gerri Lamb: And I think, you know, Terry, just follow that up – this is Gerri. Is if we look at what this measure is said to look at documentation regarding med history, allergies and meds given, it is not (Med Rec). I think what we're speaking to is, is there a relationship so that as related set of measures and in the interest of harmonizing, does this fit. So I don't think we're going down the route of combine it (Med Rec) but to at least suggest that there is some connect between them.

One question I have for Angela and Lauralei and Wunmi is is in terms of our review for March, my sense is that the data supporting importance has evolved since the lit review that was submitted with this. It doesn't look like the lit review was updated since 2007, particularly in the area of 293.

As we were saying, the current importance according to the algorithm is relatively low because of the evidence that was reported. Is that something

that we can document, request of the measure developer to shore up the importance because on the guideline, it's not very strong.

Angela Franklin: Certainly, you're saying does the – you're asking that the developer maybe present some additional information as related to …

Gerri Lamb: Exactly. You know, in terms of shoring up, at least in specific areas like 293. My impression from Pam's comment and others is that, you know, that this particular area of the communication of medication information has been better supported than some of the others. And so that we can shore up the important criteria we can.

Angela Franklin: Yes. That's definitely within the purview and I would throw it to Jill and see if that's something that's possible. And it would have to be presented before the March 18, 19 call.

Jill Klinger: I am not sure if that could be done before March 13th just because of resource constraint. I will pitch it and see what I can do.

Donald Casey: Gerri, Don. Just one minor point, too, on page 13. I did not see the inclusion of a long-term care mentioned in the denominator details and just pointed that out.

Gerri Lamb: OK. Thanks you. (Inaudible) and I will correct that.

Angela Franklin: So, we can – Jill, this is Angela. If that's something you can add in when you open the form as well.

Female: It's 293.

Angela Franklin: That's 293?

Female: I think that's what we're talking about. It says from – I'm not sure I see where that – under nine, is that what you're referring to?

Angela Franklin: Looking at the details.

Female: The denominator details, the discharge …

Donald Casey: Yes, 5.9 on page 13.

Female: Other healthcare facilities says category five.

Male: OK.

Female: We do have it up on the screen.

Donald Casey: It's a minor point. I suggest, you know, if that's enough we can move on.

Gerri Lamb: I'm thinking, Don, in the interest of time, we have about half an hour here. Maybe as we move through the other four, how about for everyone if we stay specific to the measure itself and not repeat anything that we've talked about generally about the criterion as well? Will that work for everybody?

Male: Yes.

Female: Yes.

Female: Yes.

Gerri Lamb: OK, so let's go in to 294, Rich you're up.

Richard Antonelli: Yes, I'll do my best to follow that new paradigm. And I know that Jennifer Lail, who's the secondary reader, is on the call but me sort of tee this up and I think I can be pretty brief with it.

So, this is from the Minnesota Rural Health Center, percentage of patients transferred to other healthcare facility whose medical record documentation indicated patient information was communicated to the receiving facility within 60 minutes of departure. You can see, I'm actually reading up the document so I can move quickly. I assumed you guys have that on your screen, OK.

And so the – basically, you can see the numerator statement includes patient's name, address, date of birth, gender, contact information and health insurance. And then the denominator statement is patients from the ED to other facility

with exclusions of not going to other facility. I think – Don, I'd love your notion of "it's a wonderful life" phenomenon. So, I think if I can sort of cut to the chase, I love the measure and that this stuff is really, really basic. I want to be very supportive of the – of course, of getting that information.

And Don you asked not to bring composite discussions in so I'll the respectful of that. But in the back of my head, each time I sit at the NQF, w started talking about parsimony. And so, I think probably the main struggle that I have with this measure is that it is a measure with information that absence the other stuff you're transmitting. If you don't have this information, I don't know what use medicals, you know, medication information is going to outline that being.

So, I'm actually moving done now into my list of pros and cons. It is a process measure. Without this information, outcome is obviously would be less and accessible. In fact, it's not an outcome in and out of itself.

Another con though is that the measure looks – was the information that was transmitted from the facility within 60 minutes. If there's – the reasons of close the loop aspect here is saying that the information was actually received just that it was not a lot.

And then also because it's not electronically available, they're actually looking for documentation in the medical record that information was transmitted. So, I think for the sake of time personally for this conversation, I think this is really fundamentally important but, you know, having this is one of six or seven measures disconnected from each other. I have some issues with.

Gerri Lamb: Thanks, Rich. Thanks to the parsimony too. Jennifer, do you have information to add?

Jennifer Lail: Just in the area of feasibility. I was interested that Jill said that there were no compliance about the administrative work to collect the data. And for 27 elements, it felt like to me that that could be an issue. So, that would be another question I would have if the evolution over time has moved toward an electronic collection of discrete data field.

Jill Klinger: This is Jill. There have been a number of different electronic tools that have been used for data entry. But we do not have a tool developed on any of the electronic medical record software platforms to collect the data.

Jennifer Lail: Thank you.

Jill Klinger: I think, obviously, it could be done but we haven't work with the particular software developer to do that.

Jennifer Lail: That's all I have.

Gerri Lamb: Great, thank you. Are there comments on 294?

Terry O'Malley: Hi, this is Terry again. Just – Rich's comment of nothing to indicate that the information was received is really a very interesting comment because the question is it more important that it's sent or more important that it's received recognizing that if you measure receipt of the information that adds another player in the measure, if you are to have the sender and the receiver. But in terms of patient outcome, probably receiving it is you know, you mean you have to have sent it – that's a final link. But I think that's just a very interesting comment …

Donald Casey: So, Terry. I would – this is Don. I would view this – all of these as sort handshake measures in the sense that it gets from point A to point B, so it's a good point.

Terry O'Malley: And in fact, Don, it goes back to the very first question that you raised before we get to the measure discussion about why is there a (doors) of measures in the space between. And I think this notion of closing the loop and where do you actually do the measure sampling is critically important. Which is why I brought it up here? This is far from a closing the loop measure. It's necessary but not (positioned).

And for the measure developers, I'm not disparaging your work at all. I think this really serve and characterizes right now as far as I concern much of the state of the art of care coordination measure.

Jennifer Lail: I don't feel disparaged at all. Part of the problem of connecting the dots is that it's from two data sources and they'd be judging each others work and it's complicated.

Terry O'Malley: Yes.

Donald Casey: … the care coordination

Terry O'Malley: This is Terry again. We actually, for many years of been doing this sort of – and then receive what the return or receipt requested. And it is amazing how many failures there are despite 100 percent of the time spending it information. And (inaudible) fax machine and someone's locked the office over the weekend, you have sort of a failure to communicate. So it happens all of the time.

Gerri Lamb: This discussion makes me so glad that we're going to have the discussion with the measure gaps group because, you know, I think it's Rich and Terry, you're suggesting, and certainly Don. This is feeling deja vuish in terms of the first care coordination group of what is care coordination and is it care coordination measure if it's not close loop? And it's so it's really good to revisit this. You know, and as Don was saying, "Welcome to care coordination." Unfortunately there's no easy answers but I, you know, I agree. I think this one needs to be back on the table.

Other comments?

Brenda Leath: I guess I just want – this is Brenda. I just want to reiterate the importance of all of this work and why, you know, the additional information would be helpful throughout all of the measures that we're discussing and I know for the next one that we will discuss. So, I don't want to take too much time to repeat things but I think I am – I support what has been said so far.

Gerri Lamb: Thanks, Brenda. OK, well, with that then let's go on to 295, Physician Information, and Emilio?

Emilio Carrillo: Yes, well, this is a in the same line of the seven measures. This is actually the percentage of patients transferred to another healthcare facility whose medical

record documentation indicated that physician information was communicated to the receiving facility within 60-minute. And the information is physicians or practitioners history and physical, and physicians or practitioners orders and plans.

The denominator is all the ED patients that are transferred to another facility. It's the process measure, and it's at the level of analysis of the facility.

And just to be brief, let me say it's important, it is a measure of timeliness not necessarily about the quality but similarly, it is an important component of care coordination. So in that sense, it has great importance.

There's really is a very meager evidence provided in terms of this focus. And but one concerning thing is that these measures has been around since 2007 and it has really been studied, reported on et cetera. So, it hasn't really had that much uptake since that time.

In terms of performance gaps, I think that the fact that delays are prevalent, it's something that's well shown, communication is contributing factor to 65 percent of sentinel events tracked by the joint commission. So it's something that definitely has the performance gap to address. And it's is, you know, the importance of the information is so relevant to the care – a good care of the patient that it would be something that is of high priority, of high importance.

In terms of reliability, we're dealing with all or none and the specifications are simple and well-laid out. In terms of the reliability testing, they look for 75 rural hospitals in the first round and then second round with 73 – about 1,500 in total for the first round. But my concern is that the, you know, I think that there's a world of a difference in the transmission of the information by electronic health record or by hard copy.

And in terms of the reliability testing and in terms of the usability and feasibility of the measure, that's where the proof is in the pudding, whether we're working with EHRs or we're working with hard copy. And in rural hospitals, as we've mentioned in other discussions, tend to be lower socioeconomic. The ability of the sophistication of some of the receiving

facilities to the extent that they are up with EHR, I'm not sure. It's something that I had to know more about. So I suspect that paper records would not capture the information as well as the EHR.

In terms of validity, we basically have an indirect assessment with 16 individuals who made up that expert panel and work with a five point Likert scale and they did rates, you know, high all four. I did mention that exclusions were patients going to home, to hospice, expired or who leaves against medical advice.

And in terms of a feasibility and usability, again is the issue of paper versus HER which is not pertaining only to this particular measure but just about everything we talked about.

So that sort of the summary of what I would highlight on this measure.

Gerri Lamb: Thanks, Emilio. Brenda?

Brenda Leath: Yes. Emilio, you've done such a wonderful job painting the big picture of this and many of the comments that have been raised in earlier discussions about the other measures relevant to this one, the essence of same kind of information makes it difficult to make certain final determinations.

For example, the reliability and the validity, it's definitely an important measure in my mind and has significant at the national levels because we do need to make major improvements in care transitions and having timely access to timely information. Because I would not – personally I would not want to be the patient that is moving to a different setting, and when I get there they say, "Well I don't know what to do with her." That would be just tragic for me.

So I like the idea that this measure has been developed. What I would have like to see was the result of the testing to see how it was used, whether you got feedback as a result of the testing to say that, you know, this is something that we're using, for example, to have an ongoing probably improvement drive program or that this has helped us to turn around arrays, you know, some measure that it has made an impact on the setting.

So I don't have much more to add. I think it's set that those are the things that I wanted to highlight for my assessment.

Jill Klinger: This is Jill, could I respond at this point?

Gerri Lamb: Yes, of course.

Jill Klinger: Briefly. To the first reviewer, the measure has been in a continued use, it's also reflected in the EMTALA rules. And the reason why it's in here in addition to the EMTALA rules is because the different states enforcing EMTALA rules in different ways, and so we felt that it was important to standardize that and be – have a more comprehensive piece especially with respect to plan of care. And I do have information about improvements that have been made and I can send that along as well.

Emilio Carrillo: That would be great, thank you very much.

Gerri Lamb: Thanks, Jill. Other comments?

Dana Alexander: Yes, actually – this is Dana. I had a comment, I was – pardon me, withholding until I reviewed my measure, but it just seem so timely here with the physician information measure. And that is again I think we all agree that the timeliness of the communication of the patient's information and how the information both are very important. Obviously as we move into the electronic world that will make the information, you know, readily available.

But looking at where we are today for so many facilities and at these measures, when I read up the medical record documentation, I'm assuming that we're probably talking about a paper-based medical documentation. And then as related to the information being communicated, you know, is that the expectation that communication is being done verbally or we're talking about then the hard copies that will be going to with the patient to the facility or else being, you know, faxed or how by whatever means.

In that regard then brings up the question of the 60 minutes – within 60 minutes of departure. And I'm really struggling with the 60 minutes because

if for example that the transfer is taking the patient possibly an hour or two hours, let say, to get the patient to the next facility versus maybe only 10 – this other facility that's only 10 minutes away. Well 60 minutes then, that can be a long length of time, I mean if the patient – at the accepting facility within 10 minutes, they need that information at that point in time.

And again is that then to be communicated verbally in advance to the patient arriving? Or is it about then the communication of actually the hard copy information? So I just – I raise that question and I would be having the same question as I actually review the nursing information.

Emilio Carrillo: It's a big difference whether it's EHR or telephone and paper. It's a – so some what like two different measures.

Dana Alexander: Right and even taking the EHR side of it, just take that out. I mean I'm thinking about that this is maybe paper-based in terms of the medical record documentation. In these measures where it says, "Information was communicated." Does communicated mean verbally hence to when the patient arrives at the accepting facility or does it mean that the communication was hard copy, either by fax or with the patient at time of arrival? That is not clear to me.

Male: Right.

Female: Verbally is not acceptable. It has to be sent with the patient or sent by fax or electronic, they can be scanned in. But verbally is not acceptable means of transportation. And in terms of the timing, we struggled with that. And I have to be honest with you, we have picked something that the hospitals and the providers could live with. And so we struggled with that.

Donald Casey: And so this is Don. Let me jump in and say that given the sensitivity of these from the cohort that's being measured, I understand that, but from the standpoint of patient care for, it was me or one of my family members, I wouldn't care how it got there as long as it got there in, you know, 60 minutes seems like a good thing.

So, from the standpoint of the goal of the measure to promote faster rapid access to critical information so that care can be delivered seamlessly, that is I think primarily the intent to this measure. So I want to be sure we cast this also in the light of what problem we're trying to solve and I'm certainly sensitive to what you're saying as well regarding this.

Dana Alexander: Thank you.

Gerri Lamb: Don, I'm wondering if just time check here, we have two more to go through and we also have the need to do public comment and next steps. Angela, Lauralei …

Donald Casey: You want to see if we can push through.

Gerri Lamb: You want to push through …

Donald Casey: Why don't we ask – why don't we take a poll and see – are there any people who are on the phone now wish to make a public comment when we get to it?

Angela Franklin: Operator can you – maybe it would be a good idea to open up the line right now for public comment since we had it on the agenda in case anybody dialed in specifically for that. And then we can get back to the conversation.

So, Operator, can you open up anyone trying to see if they'd like to – I think everybody should be in an open line anyways, let's just see if anybody would like to make a public comment.

Operator: OK. If you like to make a public comment, please press star then the number one.

Donald Casey: And please identify yourself too. Anyone for public comment?

We'll ask that again, but Gerri I think let's keep moving forward.

Gerri Lamb: OK. And, Don let me just share with you. I'm going to need to leave in about five minutes. So, I'll stay …

Male: Me too.

Gerri Lamb: … as long as I can.

Male: I have to coordinate care for my dad at 4:00.

Female: OK. So, nursing information 296, Dana?

Dana Alexander: Yes, OK. There will be – I think there's a lot of similarity with the physician information measures so I should be able to push through this pretty quickly. Again, this is the percentage of patients transferred to another healthcare facility whose medical record documentation indicated that nursing information was communicated to the receiving facility within 60 minutes of departure. So my issues there have already been addressed.

The denominator, again, is all emergency department patients who are transferred to another healthcare facility. Exclusions have been well-identified. Again, this is a process measure. In terms of the aspects of this measure, it includes assessments, interventions and responses.

My one question there would be is in terms of assessments that I didn't see that that was specifically, you know, defined. No specific data elements in terms of what would be expected, so maybe some clarification there. And then, of course, intervention and responses that would ago along with the assessment piece.

And in light of some of our earlier conversation, again, from a nursing assessment piece, I would see that pain would be assessed, again with medication as an intervention in response. Although I would advocate that pain would be considered in the future as a (sub) vital sign. Again, other aspects looking on assessments, impairments, catheters, immobilization, respiratory support, and oral limitation as well.

As was described earlier with the physician information on the validity and reliability testing, very similar there as well. And the inter-rater reliability, there has been – if I interpret it correctly though, some variances in the past are inter-rater reliability.

Feasibility, again, yes, this is a feasible measure that just not present – seem to present undue burden. And usability, again that it is still evolving.

So, I think again the pros on this is that – it is important for communication, handoff, and for seamless care for patients. And again, that in terms of the cons, I don't know that I really have anything specifically on the cons at this point, except for maybe some of the issues that was mentioned here.

So I think with that, I will stop and pass to the second reviewer.

Charlie Lakin: This is Charlie Lakin. You know, I must say having been recruited to this because of interest in service coordination, I really struggled with this measure and really how it is not so much about quality but timeliness, there's not so much about service coordination but record transfer. But I think that the case is easily made that it is important to transfer records promptly and accurately to a receiving hospital.

It wasn't clear to me how frequent the failure to do that was. And obviously for an measure, the capacity to discriminate between good performance and not so good performance is important. And so, the variability to me wasn't really clear. And if the timeliness is really the issue whether assessing all these different areas is really necessary, but I'll defer to people with – who are more on the receiving end and for those considerations.

I do think there was a real absence of integrating people on the receiving end to these records in the measure of the timeliness, accuracy, quality of the documentation. I just – not seem so obvious as a test of validity and so clearly missing. Obviously, experts are important concordance with professional standards are important, but does this process aid in the receiving end other than people do receive records in a timely bases.

So, for the most part, I think it's necessary, I think it's incredibly comprehensive. But is it more comprehensive than the real question that's being asked is – that is – is timely transferred done is really for others to judge.

I did feel that these things are labor-intensive process. And I would have like to have known much more about how much labor it actually took? What sort of training was in to it and so forth?

I was (trapped) as the phases of the reliability testing preceded the accuracy and probe that I was wondering really whether the early poor inter-rater agreement ought to be discounted in favor of the better later agreement, if in fact, something was done in the interim and that's to improve that.

But again, I think I was also concerned about no attention to the people who did not go to another receiving hospital. I know the purpose of this is very narrowly-defined. But the reality is that communication out of emergency room of the people who are the primary caregivers, whether that person goes to another hospital to have care given or goes home or some other place, just seems to me to be so important on this process. And if we're going to call this care coordination, we need an amplified definition of who's involved in that.

So that's my some of my thoughts.

Donald Casey: Great. Gerri, go ahead. I'll carry over the finish line. But thank you for those comments. And you hit on I think kind of the subtext in the background which is really the big question which is, is this actually measuring care coordination, we've had this discussion in other steering committee meetings. In other words, these are transactional as I'll call them mostly.

And the question is by having a transaction, does that ensure that care then gets coordinated which is the fundamental issue that we're going to have to deal with in the gaps group. But suffice to say based upon your comment, you hit that mirror squarely in the middle. And, you know, again, this is back to being necessary but not sufficient.

So, I appreciate that. I just would remind you too that there are other measures of other domains besides this one which is a targeted domain which was left out that try to address this. So, it is focused on the smaller rural communities primarily.

So, other questions or comments?

Jill Klinger: This is Jill. And I think we did improve our training. So as time went by, we realized what areas needed additional attention in the trainings. And so, some of that was improved but we also re-measured some other people.

And it is much more of a content issue done a timeliness issue where the elements covered – the meeting of the 60 minutes had not – I had to think. I don't think I ever noticed that there's a problem. But whether or not they included everything was a problem and that's where the improvements happened.

Donald Casey: Right. And this is again a measure that is used in the accountability space for the purpose of improving quality which would then require people to focus more on it by getting their processes into place, i.e. training and more specificity which is always an iterative process. So, I think the spirit of improvement is clearly there in the sense of how these measure is going to be implemented.

So, are there comments, questions? Very good. Yes?

Terry O'Malley: This is Terry. The way communication fails, is that either not accurate, not complete, not timely, and unreliable format or unreadable format, like 80 pages of fax material (outline), or that it doesn't arrive reliably. It'd be good to sort of addressed some of those that are failure modes as well.

Donald Casey: Right. Kind of like being a teenager, right? So how about – I don't have the list in front of me, Lauralei and Angela. Who's got 297, primary if they could go ahead.

Female: That will be Jean Malouin.

Jean Malouin: Yes, hi, thank you, Jean Malouin here. I will be brief because I have a minute here and I actually on the way to see …

Donald Casey: Well, do your best.

Jean Malouin: OK, so this 297. This is percentage of patients transferred to another healthcare facility whose medical record documentation included that

procedure and test information was communicated to the receiving facility within 60 minutes of departure. So, again more variation on the scene here. This is a process, level of analysis is a facility.

I think one thing – one area that this differs somewhat from some of the measures that have been presented is that there is significant patient safety issues with not communicating the results of procedures and test, could be significant time delays in treatment of a patient. And also repeating test is a significant cause to the – to the healthcare system. And having been on the receiving end of patients at the University of Michigan who have not had test including, you know, exit – printed copies – or I'm sorry, copies of MRI's and CT's and having to repeat those is just untimely and unnecessary from a cost perspective as well.

So importance and measure – I'm sorry, importance to measure and report, I think this has been described. There was a systematic literature review, I think well-documented. This type of care coordination is important and necessary. Hard to just pin it to this particular measure just like all of the other ones but I think kind of sense will tell us that this is – possibility – just pass the test is important.

Reliability and validity, numerator and denominator clearly defined. There had been three field test conducted and with have 68 to 82 percent inter-rater reliability. Feasibility, I think I'd agree with the other reviewers that one of the problems here is chart obstructions versus EMR collections but I think that's probably because there are smaller discrete data elements associated with this. It's probably more feasible than some of the other measures that have been described in terms of usability and use, nothing to really add there that hasn't been described with the other measure.

So I'll stop there and get in a minute or two so I'll turn it back.

Donald Casey: Jean, can I just ask for one quick clarification when you said systematic literature you – I think what you were saying was that there – it appears as though the measure developers reviewed the literature systematically. But I

don't think your intent was to say there was an explicit systematic review methodologically carried out for this measure. Am I right about that?

Jean Malouin: That's exactly right. Yes, I think …

Donald Casey: OK, so just for the purposes documentation I wanted to be sure about that so …

Jean Malouin: Yes, thank for that clarification.

Donald Casey: Sure. Who is secondary?

Female: Karen – Karen Michael.

Donald Casey: Karen.

Karen Michael: Hi, thank you. And I don't really have much to add to what been – over here today. I mean I think the – again we're in a common theme here. And the, you know, the comments that have already been made has pretty much address the situation.

Donald Casey: Thank you, Karen, very good. Any other comments from the group? This is hard work. Any public comments?

Jill, do you have any final words for us. I mean I think you got your marching orders here.

Jill Klinger: Yes, I have – I will send information on the current use, the current projects. I will send you the table that we did with the crosswalk with the meaningful use. I will send you some information about what improvements have been made. And I will look into the possibility of the more current literature review. And did I capture that or did I miss something?

Donald Casey: I think that's fine and we owe you some things too, I understand. Let me just – knowing that were past the hour, say that the conversation that we had yesterday prior to this evolved around the question of composite. Obviously, we're not going to be voting on that, Jill. But, you know, this was the question which will inform the future so to speak.

There's nothing we can do about it now. But I think pretty much, every one on the call would agree that this information combined sort of serves as the big framework understanding that its far different from where you started eight years ago.

So with that in mind, Lauralei and Angela, are there any other housekeeping items or any other things we missed in terms of next steps for the group?

Female: Well (Zehra) will have the next steps for us, (Zehra).

Donald Casey: OK.

(Zehra): So this is just a recap. Next step is the Work Group Call, that's on February 26th, 2:00 to 4:00 p.m., and even if your not part of that work group you are more than welcome to join in. And we would love to have you join. And then the second is the two day full committee meeting which is March 18th through 19th. And both of these should already be in your calendar. Those are the quick next steps.

Donald Casey: Great, thanks. All right, thanks to every one for a lot of hard work. And thanks to (Steph) and Jill for being here. We appreciate it. Take care.

Jill Klinger: Wait, before you go, Don …

Donald Casey: I'm sorry, yes.

Jill Klinger: This is Jill and we have out together some – somewhat of a comment about the harmonization or the combination of the measures and I would like to send that out as well for the group.

Donald Casey: OK, Jill, just so you understand – it's not to be something we will deliberate on when we vote. So it's nice to know but it won't influence our decision about each individual measure at this point.

Jill Klinger: OK, great, thank you.

Donald Casey: OK. Great. All right, thanks a lot.

Female: Thank you very much.

Male: Thanks everybody

Donald Casey: Take care. Bye-bye.

Female: Bye.

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

END