NATIONAL QUALITY FORUM

Moderator: Peg Terry
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Operator: This is Conference #93984488.

Operator: Welcome everyone. The Webcast is about to begin. Please note today's call is being recorded. Please standby.

Peg Terry: Good morning or good afternoon I should say. Hi, this is Peg Terry from NQF. I'm one -- I'm the senior director for this project. The project is the Care Coordination project and today's workgroup call.

I just want to introduce or have the rest of our staff here introduce themselves before we begin. And on the phone is Katie. Katie, do you want to introduce yourself?

Katie Streeter: Sure, good afternoon. Hello everybody. My name is Katie Streeter and I'm a Senior Project Manager. And I do offer taking the today (to join us).

Male: Sure.

Peg Terry: Yetunde?

Yetunde Ogungbemi: Thanks Katie. My name is Yetunde Ogungbemi and I am the Project Analyst for the Care Coordination project and welcome. Thank you.

Male: OK.

May Nacion: My name May Nacion, and I am the Project Manager for this Care Coordination.

Peg Terry: Thank you everybody. I do want to welcome everybody. This is our first call of two calls on this committee to look at some of the measures and to really -- the purpose of the call is to really get a sense of how the measures are evaluated and how will be organizing the meeting when you have the in-person meeting in terms of review with the measures.

I would also like to introduce or have her introduce her yourself. We have one of our co-chairs Gerri Lamb. And Gerri could you just say few words.

Gerri Lamb: I'd be glad to. Thank you Peg and thanks to all of you from NQF, committee members delighted to have you. I'm really grateful to have this chance to just go through the process before we get together (technical difficulty), and to make sure that if you have any questions that you're going through, we get some answers so that we'll have a very productive meeting in, I guess, two or three weeks. Thanks Peg.

Peg Terry: OK.

Male: Gerri?

Gerri Lamb: Yes?

Male: Gerri, you sound very, very faint. Very far away.

Gerri Lamb: Very far away, all right. So I take you off speaker. And if I lose you, I'll call back again.

Peg Terry: OK.

Female: OK.

Peg Terry: So with that, we're going to turn it over to Yetunde who do a roll call.

Yetunde Ogungbemi: Good afternoon again. I'm only going to do a roll call of the folks that are supposed to be -- or that we're assigned to this workgroup and I will ask that if there are any other committee members on afterwards, after I do the roll call, please announce yourself. Thank you.

Is Samira Beckwith on the line?

Samira Beckwith: Yes, I am.

Yetunde Ogungbemi: Colby Bearch?

Colby Bearch: I'm here.

Yetunde Ogungbemi: Chris Dezii?

Christopher Dezii: Present.

Yetunde Ogungbemi: Dawn Hohl?

Dawn Hohl: Here.

Yetunde Ogungbemi: Marcia James?

Marcia James: I'm here.

Yetunde Ogungbemi: Gerri Lamb?

Gerri Lamb: Here.

Yetunde Ogungbemi: You're back, good. Brenda Leath?

Brenda Leath: Here.

Yetunde Ogungbemi: Russell Letfwich?

Russell Leftwich: Here.

Yetunde Ogungbemi: Karen Michael?

Karen Michael: Here.

Yetunde Ogungbemi: Terrance O'Malley?

Terrance O'Malley: Here.

Yetunde Ogungbemi: Charissa Pacella?

Charissa Pacella: Here.

Yetunde Ogungbemi: Thank you. Are there any other committee members that are on -- or not assign to this workgroup?

Jeff Wieferich: This is Jeff Wieferich.

Yetunde Ogungbemi: Good afternoon.

Female: Welcome.

Yetunde Ogungbemi: Anyone else?

(Multiple Speakers)

Yetunde Ogungbemi: Barbara Gage?

(Multiple Speakers)

Yetunde Ogungbemi: Thank you. So, I just have one announcement quickly. If you did not turn your message specific disclosure of interest form which is different from the annual disclosure of interest that NQF ask that you do if you are seated on the standing committee, we would ask that you please return it as soon as possible.

Yes, please just return as soon as possible. I will reach out to those who I think that we don't have a measures specific DOI from right after call or early tomorrow morning and if you could just return that as soon as -- at your earliest (convenient) will be greatly appreciate it.

Peg Terry: Thank you, Yetunde. So, what we want to do today is for those who have actually look at some of the measures, you know that this measures are somewhat similar and we spoke with Gerri early today and many of you are actually not new to this particular project.

So, what we're going to do is we're going to start with one measure and have some people walk to that measure and I'll explain that in a minute. And then if the rest of the committee or Gerri feels we need to go on and do some with the others we certainly will.

So, which I have said, we could start with the Reconciled Medication List Received by Discharged Patients or the transition record with specified elements, either one of them we could start with and then we could take any questions as we go through. And I'm going to take a few minutes after we -- when we get to the set of reliability section to talk a little bit about data elements supposed to measure score just to clarify that for people who maybe new to the process.

I think there's one more comment we have before we get started?

Yetunde Ogungbemi: Yes, sorry. This is Yetunde again. I meant to ask if there were any developers on the call, if there's anyone from PCPI, could you just announce yourself.

Robert Palmer: Yes. This is Dr. Robert Palmer.

Yetunde Ogungbemi: Thank you.

Female: Thank you very much and…

Yetunde Ogungbemi: Welcome.

Female: And PCPI staff are here as well including Elvia Chavarria, Yvette Apura, Sam Tierney, and Diedra Gray.

Female: Thank you.

Female: Welcome.

Female: Welcome, wonderful.

Robert Palmer: Thank you.

Peg Terry: Great. So, I guess we could start with -- why don't we start the transition record we specified elements, we can go back to the med rec one if want to. With that be OK, Gerri?

Gerri Lamb: That's fine.

Peg Terry: OK. So, I'm not sure who is going to be doing the presenting. What we usually do is people, we divide up the measure and there are five elements as most of you know. And some people start with, you know, the evidence and they moved on and then somebody else to accept and that's more at the end.

So, I didn't how people want to do and who is going to present this measure. Is there anybody who will be willing to present this measure?

Brenda Leath: I'm happy to take the discussion. This is Brenda.

Peg Terry: OK, great Brenda.

Brenda Leath: All right.

Peg Terry: And so, go ahead.

Brenda Leath: No go ahead.

Peg Terry: No, I'm just going to say, we start with the evidence and we -- yes, we got it up on the screen. Thank you. Let's go.

Brenda Leath: Measure 0647, Transition Record with Specified Elements Received by Discharged Patients, and the discharges are from an inpatient facility to home, self care, or any other site of care. So, the measure is looking at the percentages of discharges from the inpatient facility.

And again, inpatient facility is defined as hospital or observation or skilled measuring facility, or rehabilitation facility and it discharge to home or any other site of care, in which the patient will goes each or the caregiver received a transition record at the time of the discharge including at minimum, all of the specified elements.

So, I'm wanting to go to highlight the specified element this (program) is clear. The elements if you look down at the numerator statement, it shows that the elements included inpatient care, the reason for inpatient admission, and Major procedures and tests performed during inpatient stay and summary of results, and principal diagnosis at discharge.

Post-discharge plus patient self-management they include current medication list and studies pending at discharge which might be laboratory or radiological test, and patient instructions.

And then there's the Advance Care Plan which would be the -- which would include advance directives or surrogate decision maker documented or Documented reason for not providing advance care plan.

Also included is Contract Information/Plan for Follow-up Care, 24-hour/7-day contact information including physician for emergencies related to inpatient stay, and contact information for obtaining results of studies pending at discharge, and plan for follow-up care. And then primary care physician, other health care professional, or site designated for follow-up care.

So in terms with the evidence, we're looking at one eight and there was a systematic review done in 2012, when this measure was first (submitted) to review. And there was documentation provided based on the 2009 transition of care (consensus transit) development of standards.

And there was also a group consensus process on which this systematic review was based in the evidence related to transitions of care between inpatient and outpatient setting.

And the transition of care consensus coming from reference closing the quality gap of critical analysis of building improvement strategies, and the developers also cited various references. There was been no changes according to the developers of (attestation).

So I'm not sure -- those are questions for process -- procedure or process. Am I to go to where the questions for the committee for the -- are we presenting -- which about these (impacted) that's just want to ask.

Peg Terry: You can just mention that if -- you need to go to the questions, so if you're going to mention...

Yes. Can I just make sure that everybody knows they can't put us on hold? So you can just -- no to the questions, not necessary, but the exception to evidence, I just like you to kind of read that. It's important for these measures.

Brenda Leath: OK. The exception to evidence, if the evidence for this measure is based only on expert opinion, it is insufficient to meet NQF criterion for evidence. However, an exception to the evidence criterion is allowed if the committee agrees that empirical evidence is not needed, the whole provides accountable for the measure and that other outcome measures as evidence-based measures are not available or feasible at this time.

Peg Terry: Great. And you can -- I don't know if you wanted to talk about the gaps part of it or...

Brenda Leath: OK.

Peg Terry: Yes.

(Off mic)

Brenda Leath: The performance gaps requirements included demonstrating quality problems and then opportunity for improvement. So they wanted to know data on current performance provided. However, there are studies underway at two CMS (sponsor programs where the intent is to generate data and summary of data from the literature showing the delayed or insufficient transfer of discharge information between hospital-based providers and primary care physicians.

So the main comment was provided to demonstrate that there is an opportunity for improvement. There is no additional information on the (disparities) of care provided. At the time of the original review, there wasn't any information provided and there has nothing any updates as of this time.

Peg Terry: OK. Does anybody else want to comment before we go on to reliability?

Gerri Lamb: Peg, is this a good place to ask questions?

Peg Terry: Yes.

Gerri Lamb: So not only comments the questions about this.

Peg Terry: Yes.

Gerri Lamb: This is Gerri. You know, I reviewed for maintenance measures. The new maintenance process and where the focus should be. And in the evidence section, the gaps, the opportunities for improvement understanding that this measure is just undergoing testing right now. There would be an opportunity and this is a question.

An opportunity to look at the literature and look at the gaps related to transitional records and whether there are particularly, you know, the gap areas, vulnerable populations. The measure developers did not provide any new references in regards to this. Would this be a place that we have that discussion in terms of awareness, excuse me, awareness of other literature related to, you know, since this, we've reviewed in 2012 related to gaps and transitional records?

Peg Terry: Yes. I think this could be a place to do that either today or at the meeting, but, yes, absolutely.

Gerri Lamb: OK. OK, perhaps when we come back to this. Understanding that there is a new maintenance process and the ones that, for today, that we're reviewing are all maintenance measures, literature related to that. We do have people on the committee who know this. There have been recent research reviews on transitional care. I don't know specifically if they addressed the impact of giving transitional care records to patients which is the unique contribution of this measure. But, I would expect to see something said about that.

Peg Terry: OK. OK.

Christopher Dezii: Yes. This is Chris. I have a number of comments. Can I just take it away?

Peg Terry: Yes.

Christopher Dezii: Great. First of all, while the -- we don't -- do we have, can we obtain any -- I understand this is -- since this is up for maintenance, maintenance has been out there and used. Do we have any sense, can we get any sense of what the impact and performance of this measure has been?

One of the things that jump out at me is that, I really like to know what the proportion of the documentation for not providing an advanced care plan. You know, to me, if that check off 90 percent of the time, that -- this tells me it's just the check off kind of issue. You know what I can hold. Can I bunny it that -- do we have an answer to what I just asked or what has happened there?

Peg Terry: I don't know. I don't know if the developer who's on the phone can answer that?

Christopher Dezii: Yes.

Female: Hi, yes. So these measures are in use in some programs and within the use and usability section, we did include information that they are not -- we do not have data yet on the comparing the use of these measures and comparing...

Christopher Dezii: Right.

Female: ...the performance on these measures.

Normally, we provide information or data from the PQRS programs. However, this measure is not within PQRS as of yet. So we do not have that information right now.

Christopher Dezii: All right.

Female: But I do want touch upon something that the previous person said about it's a performance gap. And within 1b1 on the measure submission form, we did provide some measure gap and information of that in terms of providing the detailed discharged information to patients.

Christopher Dezii: Yes.

Female: And we also included information many times what was missing from the discharge information. So for example, diagnostic test results were missing from 33 percent to 63 percent of discharge summaries, partial treatment was missing from 7 percent to 22 percent of discharge summaries and discharge medications were missing from 2 percent to 40 percent of discharge summaries.

So, we provided that information to sort of provide the -- or support the issues that a lot of these discharge summaries do not have the pertinent...

Christopher Dezii: ...information that varies. So we did provide some gap in information. We tried to provide it and update it as possible so we do -- we did provide that again within 1b1 and 1b3.

Female: Yes. That's a -- thanks. I guess you went to the other person. I understand the gap and I understand the need to fill the gap. And I guess it's a test to make sure that this does fill the gaps beyond just providing documentation. I guess that's my question. Let me say a couple of things first and I'm out of question.

The evidence does seem a little old. It looks like it's 2009 based on 2006 data. And frankly, I'm unclear and maybe after doing a better reading of the references. The references referred to the patient understanding or the delivery of the information. Evidence say -- I believe the evidence not has changed but I don't know, I mean it sounds -- I suspect you did a review to this point and did not find any and I'm not sure that's the case.

I can't ask the question if this measure is consistent with the -- if the needs are consistent with the underlying evidence because we really don't have the performances. And I guess a broader question is, is this -- is the spirit -- is the intent of this measure the provision for the information, for improve yourself management and reduce hospitalization, or -- and or just the delivery of the information to the patient. And or, or both is the discharge instruction is the requirement of this measure, the intent of this measure to deliver to the patient

for their understanding, and for them to ask as the delivery agent to the, you know, post hospital, to primary care.

Are those unclear questions? Are they reasonable? I don't know. As I read this I was really trying to wonder exactly what that is. Also, I might as well finish up. You know, I realize that disparities of care were not look at, but I don't think if it's not looked, (that the fault) is that there was not a problem.

So I'm, you know, I'm not sure -- frankly, I'm not sure if the evidence is sufficient, though, I guess it was being sufficient four years ago, five years ago. I'm sorry there was a lot in there, I apologize. Did you follow it all?

Elvia Chavarria: So, I almost -- I followed most of it, I might...

Christopher Dezii: Thank you.

Elvia Chavarria: ...ask you to repeat a couple of things.

Christopher Dezii: Sure.

Elvia Chavarria: But with the measure itself is for to assess whether patients are receiving the information necessary for -- and for them to care for themselves once they do get home and it could also be that they do provide that information to the physicians that it was intent but this -- this measure is to see and to determine whether the patients themselves received their discharge information including their medication in which ones are needed and which ones are...

Christopher Dezii: Yes.

Elvia Chavarria: ...no longer need, et cetera. So that is...

Christopher Dezii: (Period), right?

Elvia Chavarria: Yes.

Christopher Dezii: OK. OK.

Elvia Chavarria: So there -- are there are other measures that some of the other three measures that we're going to look at today...

Christopher Dezii: Yes.

Elvia Chavarria: ...address some other items and that just...

Christopher Dezii: Yes.

Elvia Chavarria: ...also that we -- because the complexity of putting a lot of data elements within one measure alone, we decided to break them up. The other issue is we did look -- look for information regarding disparities to see whether...

Christopher Dezii: Sure.

Elvia Chavarria: ...either by gender, by race, whether...

Christopher Dezii: Yes.

Elvia Chavarria: ...there was a difference -- difference and no, I was unable to find that information...

Christopher Dezii: OK.

Elvia Chavarria: ...specific for this data elements within this measure. Is there -- is information someone knows about information that is out there that I perhaps missed, I welcome that in full and I'll be more than happy to go back and look at it. But, in terms of any disparities, race or by gender, ethnic, I did not had any specific to that now.

Christopher Dezii: Thank you. I'm sorry, who was speaking.

Elvia Chavarria: This is PCPI staff, my name is Elvia.

Christopher Dezii: Elvia, yes that's what I want to know. Thank you dear. I'll have more questions for you going on.

Elvia Chavarria: OK, not a problem.

Christopher Dezii: Okie dokie. Thank you, Elvia.

Peg Terry: Any other questions or comments or discussion if -- we're move on.

Female: I have a question about the exclusions. It has two criteria that she needs cancer patients who died and patients who left against medical advice or discontinued care. And there is a reason why only cancer patients who died was use as both the -- out of patients who died with other conditions.

Elvia Chavarria: You know, what how about we move on to -- because I think there maybe an issue without exclusion, how about we move on to another question and then we'll come back to this one, to be able to provide you an accurate answer. There may -- it may have been a (typo), so I'm trying to determine whether that what base.

Female: OK.

Christopher Dezii: Right.

Barbara Gage: This is Barbara Gage.

Peg Terry: Hey Barbara.

Barbara Gage: Hi. I have a question. It was mentioned several time that this measure is in use, but I couldn't find in a materials where is -- can we have information on whether it's currently being used.

Elvia Chavarria: Yes, so this measure is being used in the CMS Impatient Psychiatric Facility Quality Reporting Program, it's a pay for reporting program. However, they just pick it up last year. So, the data submission period will be July 1st through August 15th of 2017. So that's when we will be able to hopefully access that data. But yes it's nearly -- it's been nearly implemented within that program. And again it's a CMS program.

Now, CMS does plan to include facility level measures within the hospital compare program, some time after the first submission period which again will be in the middle of this year.

Barbara Gage: Thanks. Which (PFQ) program was it?

Elvia Chavarria: I'm sorry?

Barbara Gage: Which program ...

Elvia Chavarria: CMS, it's the Impatient Psychiatric Facility Quality Reporting Program.

Barbara Gage: OK.

Gerri Lamb: Barbara, this is Gerri and others. That information is detailed in the section on usability in use.

Barbara Gage: Thank you.

Karen Michael: Hi, this is Karen Michael. Just one additional comment with respect to evidence. It's kind of surprising that there's not more evidence how to support this measure and support the improvement that improving the result could bring to a care of role. I mean it seems to be an intuitive thing, that if we do a better job, communicating around discharge and discharge follow-up that we should have lower readmission rates and better outcomes. So it's just surprising that this not more out there supporting the measure.

Elvia Chavarria: This is Elvia. So I just wanted to appoint something out. When we do our submissions to NQF, we do try to provide evidence and we are actually required to provide evidence that directly supports the measure itself and the measure data elements that are included.

So for example, there is a 2015 V.A. study that was put out on transitions of care from hospital to home, and it's a systematic review in recommendations for improving transitional care, but that's over -- overall supporting transitions of care and how they need to refer and whether they need to refer from hospital to home, and in what patient there are -- and inpatients with comorbid conditions or they done studies with CHF patients.

However, that information show up supports the need for transitions of care, but not necessarily they're not explicitly supporting the data elements that are included in this measure which again is the requirement -- requirement by

NQF which is why we were including information that no evidence is particular to this measure beyond the overall support for transitions of care is available.

Peg Terry: OK. So thank you. Does anybody who else want to chime in or have a comment, and if not, do I move to reliability? Yes, go ahead.

Terrance O'Malley: Can I make one comment, this is Terry O'Malley.

Female: Go ahead.

Terrance O'Malley: This maybe out of bounce. But is there a rationale for choosing within 24 hours or rather than at the time of discharge?

Peg Terry: The developer.

Robert Palme: This is Dr. Palmer.

Peg Terry: Thank you.

Robert Palmer: I was the co-chair of the AMA-PCPI Committee that created the fourth transition -- care transition measures. The reason for the 24-hour was simply because in many smaller hospitals and particularly where there maybe (hospitals), physicians may actually discharge a patient, when they're not in a position to complete a either a discharge summary or a list of the care transitions measures, so the document might be delayed by up to 24 hours.

Another example would be if your colleague is covering for you, but here she does not know the details of a patient, it may take them till the following day to get that information. That was the main reason. And it was not -- it was simply to capture all possibilities including (rule) as well as fellow practitioner's practices.

Christopher Dezii: Thank you. This is Chris Dezii again. How does it get to the patient the following day? Fax or I don't know.

Peg Terry: Anybody have from the developer have any interest to that?

Robert Palmer: This is Dr. Palmer again. The next one question was not specifically detailed as to how it would happen. The concept was we would leave it to the hospital and the discharging physician to determine that. So, we didn't -- we were not prescriptive, you know, whether it was a fax or phone call or what have you that would be undertaken.

Christopher Dezii: Yes. And, you know, the reason I asked that is I'm trying to come to terms with myself that this is about the delivery of the documents not whether or not the patient knows hat's going on. I guess my feeling is if something comes to the patient after they're at the hospital, there is no way, and I'm a nurse. So, you know, there's no way to provide any contact other than what's written there, you know, that's all. That's the basis of my question.

Robert Palmer: In addition, a copy of the transition would be sent to the post-acute provider…

Christopher Dezii: Yes.

Robert Palmer: ...that could be, you know, either inpatient or outpatient. So, definitely, I agree with you. That is an issue. And of course, how that -- how a form with information translates to a change in medical practice was not something that the committee could address...

Christopher Dezii: Sure.

Robert Palmer: ...but it's in coordination, I agree.

Christopher Dezii: Thank you.

Peg Terry: OK. If there's no…

Elvia Chavarria: From the developer, I just wanted to add one thing. We do have another measure. I believe its 0648 which have that 24-hour timing element to it. However, the measure 0647 is the provision of the summary to the patient upon discharge. So, it would be given to the patient once they are discharged.

Peg Terry: Right, OK. All right, well, thank you. Anybody -- so, we're going to move on to reliability and if we can just...

Colby Bearch: I'm sorry, this Colby Bearch. Can you just repeat what the last comment was because -- so, the provision of the discharge instructions wouldn't be an option for the patient, right, that's not what we're debating at all. I'm assuming that's the best practice (naturally).

Elvia Chavarria: Yes, what we -- what I was saying is that we're -- measure 0647, the one that we're discussing right now.

Colby Bearch: Yes.

Elvia Chavarria: We don't have that 24-hour element to it. Its measures 0648 which we will be discussing subsequently which is a 24-hour timely transmission of the transition record to the facility who is taking over the care on the patient. And that information needs to that receiving facility within 24 hours so that the information is available to them and whether that's by fax, whether that's by EHR, it would be up to the facilities to determine that. But for measure 0647 which we have before at this point, we don't have the 24-hour requirement because the (intend) for the summary to be provided to the patient upon discharge.

Colby Bearch: Great, thank you.

Christopher Dezii: That makes sense, thank you.

Colby Bearch: Yes.

Peg Terry: So, we're going to move on to reliability and if somebody would be willing to discuss it and then, when we sort of finish that I'll talk a little bit about the algorithm that is used for this particular area. So, who would like to go to the reliability? The people assigned to this? I don't...

(Off mic)

Peg Terry: Yes.

Gerri Lamb: This is Gerri, I'll do it.

Peg Terry: Thank you Gerri,

Gerri Lamb: Sure. OK. So, we all have the algorithm two for reliability, testing the data that were shared on this were at the data element level, not the measure score and we'll go back to that in just a moment in terms of the differences, OK. And the data were provided at the patient level and I believe it was submitted with the data from the original testing. And -- let's see if I can go back to this.

OK. OK, here we go. OK. And the data from -- that was reported showed 88 percent agreement with the kappa of 0.69. And again, this was from the original testing. The most recent testing in the QRF is not available yet. And just to point out that empirical testing was not submitted with the computed performance measure which is an issue in all of these and I think I'll just stop there, and Peg, if you can provide an overview of that.

Peg Terry: Sure. And we have an algorithm, see if we can find it. We can just pull it up for quick minute here.

Of course, can you make it a little larger if possible?

So, as you probably have seen if you looked at our -- the measure evaluation criteria guidance in what you have in the committee book, this is what we use to evaluate measure. This is our standardized way of doing it. So, we -- for reliability, we start with the (issuer) are submitted specifications precise on ambiguous and complete so they can be consistently implemented. And then we look for definitions, we look for (values) codes, descriptions, and yes, we have specification for this measure as been discussed a bit earlier we're talking about the measure itself.

Was the empirical testing conducted using statistical test with the measure specified and it was not? So that issue you looked at -- this is how the NQF does it. If you go from the box that has two, to the box we go to no. And then was empirical validity testing of patient level data conducted, and that is a yes.

So, what we do at NQF is we actually go and look at validity. And so, we -- because this is patient-level data, and what we do here at patient-level data is that it's compared usually an inter-rater reliability way and it's compared with

two sources here to electronic health record and I believe the data collection, manual data collection.

And the -- when you go validity, (go) to the bottom you can find this file, this algorithm that we have here. Then at box 10 here on validity, look all the way down, (it's) how we do this when we talk about OK, the validity testing conducting the patient-level data element, yes it was. Was the method describes appropriate for assessing the accuracy of the critical data elements? Yes.

And what they have here is they talk a little about what's the testing they did and the testing they did was inter-rater reliability and they came up with the kappa score.

The problem with this measure if it's done here. And if you look under, where it says, answer no if only assess percent agreement. But here they did not assess separately all he data elements and there are many data elements here. And we just have one statistic which is the minimum -- which is, I'm not sure, I think it's the overall but we should have a numerator, denominator and an exclusion for data element testing.

And so, that's one of the reasons that this measure is not sufficient because the testing was only done with one single kappa value that was provided. Does that help at all, Gerri?

Gerri Lamb: Go back again. I understand the one kappa value because this is going to come up in all four of the measures. So, that answer no if, only did not assess separately for all data elements so that the expectation would be, is that the kappa would be separated out for each of the data element, is that correct?

Peg Terry: That's correct.

Gerri Lamb: OK. That's -- does everybody understand that because I got kind of lost in the algorithm.

Christopher Dezii: Yes, this is Chris Dezii again. Just to note too, I believe that the other two measures, there's a cluster of three that have the same evidence base, the same reliability testing. We'll see when we move on, just I guess everybody...

Gerri Lamb: Yes, Chris, that's actually why I ask Peg to do this it's because of the same issue across all of them...

Christopher Dezii: Yes.

Gerri Lamb: ...and it's also one of the reasons that this cluster of measures some of them group together are being recommended for not moving forward. So, I wanted to make sure everyone was clear on this. So, thanks for bringing that up and thanks Peg for reviewing it.

Peg Terry: OK.

Christopher Dezii: Yes.

Diedra Gray: Hi, this is Diedra PCPI. Can I add a comment here?

Peg Terry: Sure.

Diedra Gray: I just wanted to -- well, I appreciate your explanation of the challenge with the testing data. This is some of our original testing project. And so, what we essential did was we just didn't update any of the testing information because in our original NQF submission the overall kappa statistic was unacceptable result.

So, I just wanted to offer that although I don't have access to the data as we speak, I'm happy to go back and look at the data from the original testing project and see I we will able to calculate the kappa for the numerator, denominator and exclusion as required by the new NQF process. And then we can -- if we're able to do that then we can -- we would obviously, you know, submit that as soon as possible so that you would have it in advance for the steering committee meeting.

Peg Terry: Absolutely. You can do that and that would be very helpful. And I'm not sure if we have changed our requirements a little bit, we may have. I wasn't here then but probably we did. But that would be very helpful if you could find the -- more details on the numerator, denominator and exclusion.

So, would you just -- after the call just shoot me shoot us an e-mail and just give us a sense of your timing on that?

Diedra Gray: Sure, we can do that.

Peg Terry: Great. OK. Any other comments or questions?

Brenda Leath: And just for my own clarifications. So you will address the issue about the cancer patient that it's part of your exclusion in your follow-up, is that also true?

Female: Yes, I was just looking at our submission form and the exclusions that we have listed were patient left AMA for this particular measure 0647. So, we -- that's actually not exclusion for this measure the cancer patient. So that is not appropriate for these measures. So, I apologize if somehow something got mixed up but it was not included in the original submission form so that is not again an exclusion.

(Off mic)

Peg Terry: So, could you also -- I don't have that in front of me where exactly came from but this is Peg Terry again. Could you just send us that in writing?

Female: Yes, that's not a problem at all. And again, I'm just double checking the submission. But yes, certainly, I can send it to you in writing. And I'll resend the information that was provided on the submission form with only one exclusion.

Peg Terry: OK.

Karen Michael: So, this is Karen Michael. Am I correct that the expectation is that when a patient dies that we would still be transmitting a discharge summary and reviewing it with someone?

Female: No. No.

(Yvette Apura): Hi, this is (Yvette) fro PCPI. So for this measures we have two exclusions, patient who died and patient who left against medical advice. So, those are the two exclusions for this measure.

Female: But not potential one.

Female: But it's not potential. We'd agreed -- we're not -- the patient who dies is not limited to cancer patient.

Karen Michael: All right, thank you, I misunderstood. I thought you were saying there is only one exclusion. Thank you.

Female: OK. Thank you.

Female: Thank you.

Peg Terry: OK. So, onward to validity, and who would like to talk about validity as related to reliability that we just talked about? Does anybody want to go through that?

Gerri Lamb: And since I did reliability I'll just move on validity. This is Gerri.

Peg Terry: Thank Gerri.

Gerri Lamb: The validity testing was based on that same data set that we just talked about and where it becomes important is because of the algorithm that we just reviewed. In terms of any type of validity testing, face validity was presented during the initial review. So, with that offer to get the reliability testing in the kappa for each of the different elements we should be able to address this.

Peg Terry: Absolutely. And I would say if -- just to add to that, I know the face validity is new this time but it is -- if there is some kind of validity testing that is empirical validity that is presented or other validity testing we -- that sort trump the face validity testing.

Charissa Pacella: This is Charissa Pacella. Can I ask if there is some mark for the face validity testing? I mean, some -- as submitted how well the measure would do on that measure?

Peg Terry: Could you ask that question again? I'm not sure what it was.

Charissa Pacella: Sure. So, for each of measures with the face validity testing, we have a number people who rated agree or disagree basically that success on the measure reflected quality. It's a single statement are being asked to agree or disagree with, is that correct or not correct?

Peg Terry: Right.

Charissa Pacella: OK. So, my question is if a measure performed very well in face validity we would expect that to be 100 percent. My question is how does an 81 percent which is with this one was I believe fit with what's good or not good. It seems to me that three people out of 11 saying that the measure was useless or not useless but either, you know, disagreed there are (effective) quality or at best were neutral is hard to say that everybody, you know, that face validity is great.

Peg Terry: Are you -- if you're asking NQF, I can just say that we don't have specific on where it needs to be. I think it's 72 percent here, and so, it's sort of up to the committee to weigh that result. The statement they made is perfectly is fine, you know, but whether that's high enough percentage it's really up to the committee.

Charissa Pacella: Got it.

Peg Terry: Any other -- Gerri, is there anything else on (rest of) validity? And we know it's just patient who died, not cancer patients in the exclusion (we’re aware of that).

Gerri Lamb: Right, right. And I think just for the meeting in couple of weeks, the question that I think it was Peg just raised, please do kind of conjugate on that because it's going to come out at the meeting in terms of the new information we were provided on face validity. So, if we can think of that in advance and kind of

produce the content validity literature in terms of the 72.7 percent face validity agreement, that'll be helpful. I don't think I have anything else to add though, Peg.

Peg Terry: OK. And so, was somebody like to discuss feasibility?

Christopher Dezii: Yes, this is Chris. I'll jump in here and get this -- get my contribution out of the way for a little while.

Peg Terry: OK.

Christopher Dezii: Well, you know, we understand the feasibility is the extent to which the specs include the logic and the required data that's readily available. I thought it was interesting. This measure is coded by someone other than the person obtaining the original information, and abstracts it from a record by someone other than the person obtaining that original information toward extraction or registry.

Though, I will note that the developer noted that the -- it does not land itself to a traditional specification for EHR where date elements, logic and coding are identified to calculate the measure due to the fact that every facility may have a different templates for transition record and the information required for this measure is based on the individualized patient information.

They have however -- the developer has, however, provide the guidance on how facility should query the electronical -- the electronic health record for this information within the numerator details. And of course, I will go back up to the numerator details to see if I can (tease) it out to there. Or since we have the measure developer on, can you fill in the blank there for me about what that guidance say, please? Or am I cheating?

Female: No, it's -- if we're able too.

Christopher Dezii: OK.

Female: Would you repeat the question?

Christopher Dezii: Sure. If you could provide -- the developer -- you provide the guidance on how a facility should query the EHR for the information required for the measure. It's said it was in the numerator details. I'm not sure I saw it there. Or do you not know what I'm was talking about.

Female: Right. No, I know what you're talking about things. Yes, so we provided that guidance on S.5 on the form. And we provided best guidance that how to produce the transition record specified elements. And we also provide guidance on transmitting to transition record with specified elements...

Christopher Dezii: Yes.

Female: ...and systematic external reporting of the transition record.

Christopher Dezii: All right.

Female: Do you want me to read guidance?

Christopher Dezii: Yes, please.

Female: Sure. So as far (as we do things that's transition record) with specified elements, (specifics) that have implemented an ERH should utilize the system to produce the standardize template that providers will complete to generate the transition record.

A standardize template will ensure that all data elements specified in the performance measure are included each time a transition record is prepared. Each facility has autonomy to customize the format of the transition record base on clinical workflow, policies and procedures and the patient population treated as the individual institution.

As far as transmitting the transition record with specified elements, we provided guidance that this performance measure does not required that the transition record be transmitted to the next provider of care.

Christopher Dezii: Yes.

Female: However, if the transition record is transmitted to the next provider of care, it should be done and so in accordance with established approved standards for interoperability. The ONC Health I.T. Standard Committee has recommended that certain vocabulary standards are use for quality measure reporting in accordance with the quality data model.

In addition, the use of recognized interoperability standards with the transmission of the transition record information really ensure that the information can be receive into the definition EHR. And also, in order to report a facility level which of the discharge patients have received, a transition records, a discrete data field encode indicating that the patient received a transition record of discharge (may needed) in the AHR. So those are -- those statements are included. We included them in F.5 section.

Christopher Dezii: Great, thank you. I don't have anything more to say.

Peg Terry: OK, any question on feasibility?

Barbara Gage: This is Barb.

Female: Oh go ahead Barbara.

Barbara Gage: OK, thanks. That was a great last question about the transferability but while the hospitals and the physician offices have been ramping up to be able to exchange data, the PAC providers as mentioned here the (ERBs) and (SNIF) et cetera don't necessarily have that capability, has there been consideration of how that information can be received without that system?

Yvette Apura: OK, so, this is Yvette from PCPI. So if they cannot, you know, if they cannot transmit the record to the ERH, then they can use the difference format, like fax or whatever they have available. Now in this -- for this measure, we get provided like a guidance for them just in case if they wanted.

Barbara Gage: OK, this is very helpful. I'm actually working on related metrics under the IMPACT Act and because the post-acute care providers were not included under the (R) legislation which talk about the development for the Meaningful

Use system for the hospital (to most) physicians, and it certainly been a barrier of how to transfer information at time of discharge.

Terrance O'Malley: OK, and hi. This is Terry O'Malley. I just want to piggy back some Barbs commit. Do you have any guidance on how our facilities can be -- how should they measure the fact that this is actually occurring? And how do you know the information is transferred? How do you know that the patient got it? How do you know they got an (enough) format that would be useful that they could read and understood? I mean there are layers of sort of the connection between packaging this information up so you can tell what left the door as supposed if you're doing it through EHR. But the other question is, so what arrives to the point of use and how do we know?

Peg Terry: Does anybody want to answer that or need for further classification?

Robert Palmer: Hi, this is Dr. Palmer. The next one question, when we devised the measures, we acknowledge that that is a limitation of the measures. There's no way of actually proving that they were read let alone implemented. So, it's a limitation. But as a starting point, getting that information out in a timely fashion was considered the priority.

Terrance O'Malley: OK, any -- that make sense. Any recommendations in how somebody might approach that question?

Colby Bearch: I just want to -- and this is Colby. I just wanted to comment in all that as well. In some of the model, I know we're talking about fax and electronics and transmission of the health record, but as well, at least where we are. There are several systems where coach partners then with the healthcare team help coaches. And they help to facilitate this as well, but I think the limitation piece comes to light even more vividly in the construct -- the coach construct, coach medical team construct for post-discharge care because, again, it's a persons who maybe (very late) person.

And even though they're there to help them facilitates some of the things that have to go along with the discharge and the movement back into the community or whatever situation that going into, still are they able to read and

understand what's going on. Because then it's kind of like you just have another person not knowing what's going on.

So just a little comment there. A lot of times that it's not -- there is some, you know, movement information but the healthcare, these are also helping to facilitate movement of that information.

Peg Terry: OK, that's -- does anybody have any further comments or questions and we can just move to usability on this one?

Male: Yes, this is...

Gerri Lamb: Just a general comment. And I think this is more for the meeting than for here is I think this is a really important discussion that at least in my view gets us to the question sort of retrospectively of importance

And so, I think what we've moved to is some of the gap areas on measures that are for maintenance review. And I think on the -- in the meeting, we had asked for, you know, a review of the framework and some gap areas. And this would be really important to bring up at that time so that we really are very focus on our review of the maintenance measures what they were intended to do at the time that they were put forward and where we are now in terms of the state of the science, so just to bring that out but not on this measure. I don't have anymore comments specifically on the feasibility for this measure.

Peg Terry: OK, thank you, Gerri. Does anybody just want to talk about usability for this measure?

Karen Michael: Hi, this is Karen Michael. I'm happy to start that off. So as we discussed earlier, the measure is going to be included in the CMS Inpatient Psychiatric Facility Quality Reporting Program for the period for July 1st, 2017 which we want the first day to comes out. And eventually, CMS will plan to include this in the hospital compare public reporting program.

So, there is one accountability application and publicly reported within the timeframes. In addition, in 2016, the dual eligible beneficiary workgroup, both include measure in the start of set of measures that they're going to be

using for that program. So, well, it is fairly limited because we're talking about inpatient psychiatric admissions only at this point. There is some public use of the measures for that.

Peg Terry: Thank you. Any comments?

Christopher Dezii: Yes, Chris Dezii. This IPFQR, is that related to the Hospital-Based Inpatient Psychiatric Services for which I believe NQF has -- or the Joint Commission. HIBP -- HBIPS, seven and eight, is there any -- does that mean anything to anyone? Did I just said that? No?

Female: I'm not sure.

Christopher Dezii: The only -- the reason I brought it up is because I found the recent letter or isn't that recent. But in April of 2015, the American Hospital Association, the Joint Commission, National Association of Psychiatric Health Systems suggested that there's almost a redundancy in measures with the HBIPS-6 and HBIPS-7. And I was just drawing that out there to see if that issue had been resolved. And my sense from -- I get the sense nobody really knows what I'm talking means that it may not have.

Barbara Gage: Are there -- this is Barbara. Are those metrics possibly related to the basic inpatient site psych reporting program...

Christopher Dezii: I believe. Yes, I believe. I believe so.

Barbara Gage: So we probably look at that.

(Multiple Speakers)

Christopher Dezii: I'll send you what I have, NQF folks, OK?

Peg Terry: That'd be great. Thank you.

Christopher Dezii: Or rather who's name comes to me (off the table). The last e-mail I got was from Katie. So Katie, if you're out there I'll send it to you and you can get around to everybody, OK?

Katie Streeter: Sure, OK.

Christopher Dezii: OK. I don't have anymore.

Gerri Lamb: I have a question about in an earlier measure I don't see it here under this measure. Is there -- this is an NQF question. There was something about a criterion of the testing should happen within three years of when the original consensus measure move forward. Is that the case? Because I wasn't aware that -- oh here it is, OK, or expected to be use at least one accountability application within three years and publicly reported within six. So that -- we have this issue and I think most of these four measures is that some of them are just moving into public reporting now. How closely does NQF look at that criterion?

Peg Terry: I don't have any answer to that, although it sounds like the timing is very close actually to when you met before. So, you know, I don't know that that would be an issue but I can find out. I don't, you know, I think that's the recommendation and just keep in mind that usability is not the must-pass criteria. So I just want to mention that. And that's why I gave you really a very good answer but I'm not sure.

Gerri Lamb: No, but that helps to understand where the balance is because the most recent endorsement was in 2012 so that -- you're right, the window is closed but I just wondered because it was mentioned in some of the -- in some of the summaries and not (at all), so I just wanted to check on that.

Peg Terry: OK. So -- and -- so at this point, is there any other questions on this? So Gerri, do you think it would be valuable to go to another measure?

Gerri Lamb: Let me summarize and then let's see what everybody thinks, OK?

Peg Terry: OK.

Gerri Lamb: My thought here is rather than go through general issues again that may not be necessary, but if people have specific things related to the other three measures that might. So here's what I was hearing with the evident -- with

each of the reviews is that in the evidence review, if there is new evidence out there, it needs to be specific to the measure and it's intent.

So if anybody is aware of new evidence related to these four measures, it would be a good thing to bring it forward. And I did hear the PCPI team say they would be very open to hearing that as well. So, that's a general issue related to evidence specific to the measures and there intent.

The reliability -- I think it will be really helpful to get the new reliability information that we discussed earlier as well as for everybody to think about the issues that we raised about content validity, because that is consistent across the four.

On the visibility front, I don't know that they were any outstanding issues other than access to the data and a judgment call on how hard is this going to be to get this data.

And then in terms of usability, I think, again, common issue across is that many of these four measures are just going into public reporting now. So we will have discussion about how important is this and how would it play into the rating. So, those are might take a ways in terms of general issues that go across all for.

And I guess, Peg, if you go back to your question. What I would do now is just throw out to the group. If first off did I miss any of the general things into, if anybody has specific issues that don't go to the general issues for the other three. Does that make sense to everybody?

Christopher Dezii: Yes.

Male: Yes.

Karen Michael: So, this is Karen Michael. Just one specific issue for this measure that doesn't necessarily hit all of the others is the ability to complete the documentation with respect to the patient understanding of the instructions. I think, you know, having that as a part of the measure is a very -- put a very subjective element in.

Gerri Lamb: OK. And, you know, in terms of where the -- where we might bring that up because that is a critical issue. So I'm wondering on that Karen is that -- are you thinking that that would be -- when we get together, we do -- we did else for time in terms of gap discussions, and whether the patient understand this or not, was not part as I understand it and please PCPI team jump in. That was not part of the intent of this. It was just where they given it. OK?

Adding the literacy and the understanding, at least if I'm understanding this correctly, is a new piece that we are saying is important. So if you're going to give the patient information, do they have capacity to understand it is a separate issue? Is that correct?

Christopher Dezii: I think, yes.

Female: Well, the women...

(Off mic)

Female: From the measure developers and we often hear suggestions on making changes to our measures. So we do have a process in by which we do that. We have a technical expert group, Dr. Palmer is on it. And what we do -- what we would do is we would take any -- so the measure as it extends now is the one that you will be -- or that you have been considering.

So any changes through the measure, we would need to bring toward technical expert panel and through a process of evidence review and this is that we've been brought up, the understanding piece. But as Dr. Palmer said, we want to get to the first step in making sure that this occurs. And then just providing the information to the patient, whether we expanded to try to determine and then what data elements would go into actually determining it -- determining and indicating whether the patient actually understood the information that was provided that it's beyond the scope at this point of the measure, but certainly something that we could take to our experts and see -- and determine whether that change can be made at some point. But the measure as this is what is under consideration.

Karen Michael: Yes. And actually I -- and so I stand to correct it, because the actual specification is -- was going to review of the information with document and so it does not address understanding. So, thank you. I withdraw that comment.

Christopher Dezii: Now, this is Chris Dezii. I think that's a reasonable comment. And this is what we struggle with all the time. I mean, process measures are important. But, frankly, they are important to be able to get to that shining city on the hill to really identify whether or not these things matter or not, like the feasibility issue for the proportion of facilities that can't deal with EHR transfer, it's kind of still up in the air, right? Because there really isn't guide -- the guide for that is for folks to develop templates that they could share back and forth.

I have a sort of -- I don't if it's an unfair question, but I throw it out there because I have my own opinion. Would the developers have any sense of the personal grading of the evidence that exist for this measure as it stands right now? I mean, I don't see it as an A at all, but I'm just wondering if I'm off base here. Or, would you rather withhold judgment on that? I don't know.

Robert Palmer: This is Dr. Palmer.

Christopher Dizii: Yes.

Robert Palmer: Could I just add, no, it's a excellent question. Actually the measures were developed because of the lack of any measure to define care transitions.

Christopher Dizii: Yes.

Robert Palmer: And if you review the literature from -- up to 2009, it really captured the absence of good handoffs...

Christopher Dizii: Yes.

Robert Palmer: ...information from one site to another site and then from any site to the patient. So, the evidence is basically not terribly changed in terms of the absence of good handoffs. There are studies that haven't proved handoffs, for example, among (hospitalist) certain programs that really focus on that, but

have demonstrated the absence of an issue that, you know, the recent for the four measures being developed is still an issue.

Christopher Dizii: Yes.

Robert Palmer: So, but to your point is well taken.

Christopher Dizii: Well, you know, and it's -- and, you know, it's -- you have to compromise. You know, it's much better that the alternative, right?

Robert Palmer: I agree.

Christopher Dizii: In other words not having anybody monitor or performance measure for handoffs. And, you know, I understand that. So, I guess let's puts it back into the judgment (round) for us and that's fine.

Gerri Lamb: You know, I think, this is a great discussion related to ongoing discussion in this committee for many years in terms of where the gaps, where are we at in terms of the state of measurement. And what this conversations speaks to me about is the whole idea of necessary but not sufficient.

Christopher Dizii: Yes.

Gerri Lamb: This measure was intended to get us started. We should really take a look at -- if we don't transfer the record, there isn't the chance that the patient...

Christopher Dizii: Yes.

Gerri Lamb: ...is going to understand it or use it, but it goes beyond what we want now. And there's an issue here of, you know, baby in bath water and it's a tough judgment call and I think we're going to need to probably get into it when we get together. But, you know, I think we all need to appreciate where this measure was coming from what it was intended to do.

And then have that discussion of where do we need to go from here and in the year that we haven't had face to face. You know, we've talk about this and hopefully -- I would just encourage everybody to review the summary of those discussions for that meeting, so -- because we only have a day together and

this is -- as we're all saying, very important stuff. So, I appreciate the discussion greatly.

Let's -- if we could go back Peg is -- so we've had this general discussion and I think this was a good choice, this particular measure for having those general discussions. Can we throw out if there's any specific questions related to the other three that don't get into this general issues?

Female: That's a good question.

Charissa Pacella: This is Charisa Pacella. I have a specific question related to 0649, the one that relates to the transition record from the emergency department to home. My question is this, from my reading through the documentation in prior discussion it doesn't appear that anyone has ever looked at transition -- at this for E.D. discharges as evidence to support this or in the review of the measure where it's just sort of extrapolating or applying data from other setting.

And my related comment would be that the process of discharging patients from the emergency department is quite often different from the process of discharging patients from inpatient settings depending on the hospital. And so, I'm wondering about whether that's applicable and whether it would really essentially need new data from reporting in order to be able to assess it.

Peg Terry: So, your question is for the committee and the developer?

Charisssa Pacella: The question is primarily for the developer just to ensure that my reading is correct that no one has look at emergency department discharges -- discharge data for this transition of care, that's the first one. And then the second question is, is the current data being collected that will be for review in future cycles? Is there any emergency department specific -- is there data specific to this measure?

Peg Terry: So, is there somebody from PCPI can talk to this?

Elvia Chavarria: Yes. This is Elvia. And we didn't find information specific. You're right, we did extrapolate from -- we haven't extrapolated from other settings, not necessarily. I don't believe this measure -- I'm trying to determine what the

use and usability that we provided was to determine whether that information will be available.

I know that we did have emergency physician on our expert work group who were able to provide information on that, but, yes, after this measure right now the use in unknown. So, not sure whether we'll be able to have that information available.

Christopher Dezii: Would that...

(Multiple Speakers)

Christopher Dezii: Quick question. Would -- Elvia?

Elvia Chavarria: Yes.

Christopher Dezii: Would you have the ability to do that research?

Elvia Chavarria: Before the meeting?

Christopher Dezii: No, no. Here's what I'm thinking. I mean, you know, we're talking about where we need to get to and...

Elvia Chavarria: Yes.

Christopher Dezii: ...you know, it would be much more palatable to me. You know, I realized that, you know, some (ERS), boom, boom, boom, here's your form. You know, good luck (go seek) follow-up. If there can be guidance and recommendations as -- you're the measure steward, right?

Elvia Chavarria: Yes, we are.

Christopher Dezii: OK. I mean, if there's a role or a place or -- and I guess here's the question for NQF if it's within our purview to offer recommendations that, you know, this is nice. Go forth and multiply. But by next amendments we would really like to see data related to this. Is that like beyond the (pale) of what it is that we do?

Peg Terry: No, I think you can -- this is Peg from NQF. I think you certainly can make those recommendations. I think we review those and that's part of what we so, so that would be great.

Christopher Dezii: Yes. I mean, it would get us -- at least moving in the right direction for where it really where we all need to go. Now, you know, from PCPI standpoint, I realize, oh geez, you know, it takes money to do this and, you know, it takes work and I guess that can be -- I don't know if we can maybe figure it to get it done. All right, I'm done speaking it. I'm done.

Female: All right.

Elvia Chavarria: No -- this is Elvia from PCPI. We certainly appreciate that suggestion and absolutely we're always trying to improve our measures so we don't just...

Christopher Dezii: Sure.

Elvia Chavarria: ...develop and then put them on the shelf and hope, you know...

Christopher Dezii: Yes.

Elvia Chavarria: ...and then (admire) them from a far. So we are looking for ways certainly to...

Christopher Dezii: Yes.

Elvia Chavarria: ...improve our measures. So that certainly that something that we can take back and try to do -- determine how to best address that, so.

Christopher Dezii: Yes.

Elvia Chavarria: So, yes.

Christopher Dezii: Yes. I mean...

(Multiple Speakers)

Elvia Chavarria: Yes, it does require resources. So we're trying to figure that out and at least have a conversation.

Christopher Dezii: Yes. I mean -- and, you know, to get -- I said, I'm going to shut up, but I keep talking. Just essentially to start to really get the measures that matter. You know, I've realized the importance of process measures but, OK, we need an immediate outcome because we need outcomes. We, you know, OK. Now, I'm done. Thank you.

Dawn Hohl: Hi. This is Dawn, Dawn Hohl. And it seems the previous speaker and I'm terrible with catching all the names. I wasn't going to bring this up, but I just going to sort this out. It's a longest thing line. It's far beyond the scope of today, but looking at tomorrow. Now, I am looking more at the med rec and coming from the home care background, I recognized the importance of having a reconciled med list.

Christopher Dezii: Yes.

Dawn Hohl: But, I would also advocate for the outcomes of reconciling the medications to the list, because from the home care perspective we can have a very accurate list and have a very inaccurate collection of medications.

Christopher Dezii: Yes.

Dawn Hohl: So I would just advocate, you know, and maybe, again, you know, we don't have today's resource put down the line that tends to be the more important outcome.

Christopher Dezii: Yes. This is -- sorry...

(Multiple Speakers)

Gerri Lamb: So along this lines, I would just ask everybody because, you know, I know how committed everybody is to this work, is please do bring those issues and concerns. Again, we're not going to have a lot of a time in a one day meeting and we know that there are significant areas that the measurement of care coordination needs to move to. And we have an opportunity together to put those down and get them summarized to NQF, you know, with the

measurement development community. So please, do bring those along with you so that we can put them on the table and get them organized.

Are there any other questions about specific measures, not the general issues, and certainly document the gap areas that concern you.

Terrance O'Malley: Yes. This is Terry O'Malley. Just a follow up on the 0646 comment on the med rec for home care in particular because that -- actually home care probably has the best chance of the most reasonable approximation of the actual medication list that the patient is going back to.

But, I was just wondering if the measure developers had any specifications about the process for developing the preadmission medication list, because everything is predicated on an accurate list of what the patient was on before so that could be then compared to what there -- in the hospital with. And I don't see any specifications for that and I'd be interested to know how much work does it take -- how much work do you need to get a list that you're satisfied with, I guess.

Robert Palmer: Hi, this is Dr. Palmer. Medication reconciliation has been the Achilles heel of every hospital and every physician who admits patients, so it's a big issue. No, there was no specification because at the time and I think things are not that radically different. There was no standardized or required process of reconciliation.

In other words, reconciliation, particularly Joint Commission was one of the national safety goals, but when they did audits, reviews of hospitals, they found that nobody was actually doing it well. So we could not be more specific. The hope was that I raising, I guess, the issue. You might create the process, but there was no standard specification.

Terry O'Malley: No, I would -- maybe that where it goes and there's a gap category, because that's -- it's such a good measure but it's -- but we really need to nail that first mile in order to make it really effective and get the measures that matter. And getting an accurate post-discharge medication list, it is this close to what the individual was done before they came in to the hospital and which by the way is the (bane) of home care.

Male: Yes.

Terry O'Malley: You know, it's really the gold standard. I mean, that's where we really want to get to.

Female: Yes.

Terry O'Malley: So I put that in a big bucket of gaps, that's a...

Barbara Gage: This is Barbara Gage. I'd like to echo Terry's comment in our work where the CMS where we are looking at med reconciliation in the post-acute care world. So starting with post-acute discharge, you know, either another post-acute care provider for discharge home without additional healthcare. These same issues are coming up and I can tell you up to date, there is no accurate form. There's no formal process that has been put forth and we've been working closely with the pharmacy community and the geriatrics and the internal medicine communities and home health care, of course. So it's a big gap.

Christopher Dezii: One last item from Chris. All these, all these wonderful talk really strengthens my tolerance for existing measures identifying, you know, that they need to be in place to get to where we want to go. Absent that, they look like dead measures. So my point is, let's continue to talk about the stuff because this is the rationale to really have these measures turn into steps to get to the right place.

Samira Beckwith: This is Samira. I've been quiet throughout the call just because I want to learn and understand the process as well as get to know people. But I think your last comment was really very important, because as I've listened and I think about all of these measures and the entire conversation about process versus outcome and, you know, we've been having this for years. And I think unless we're taking the right steps and process, we can't even get to an outcome. So, I found that to be very helpful.

Peg Terry: And any other comments? And Gerri, it's sort of up to you at this point.

Gerri Lamb: All right. Well, a couple of things. One, this is -- this has been a great conversation and I think we have, you know, kind of identified and I will bring this to the discussion tomorrow, some general issues that we can all look out. We also have a beginning with the gap issues in terms of the transition record, did patients understand that literacy, the med rec, and I appreciated the frame of the Achilles heel that sounds pretty accurate to me.

And, you know, if somebody who has chaired standing committee for a very long time, it's very satisfying to have a sense of the history of where we were, where we need to go and I for one really appreciates the emphasis on moving towards meaningful measures. You know, when you think about the fact that these measures, most to the ones we're reviewing today, we put forward six years ago when we had almost nothing. And the fact that we're dissatisfied with them now is a good thing, OK.

We have to put them in context of where they've been, where we're going and what we need in the future. And so I'm just absolutely positive we're going to have a very robust and useful conversation.

One thing, Peg, I would ask for and I don't know if it belongs here or in the next step, is in my recollection when we did measure reviews in the past, we had an identified lead person and an identified second. And I'm thinking that would be very helpful if that hasn't happened to see that folks know, especially because we all got the guidelines for presentation, whoever is lead needs to be prepared for that and to follow the guidelines so that we can get through it because if we don't get this through this in timely way we won't have time for gap discussion. So can we have people identified as lead and second in each group?

Peg Terry: Absolutely. We will follow-up with that and we'll get that straight and update for the meeting and we have enough people for these measures, so it should not be a problem. We may need a backup, so the back up people should be ready.

Gerri Lamb: Is that OK with everybody if we do it that way?

Female: Yes, that would be helpful

Female: Yes.

Female: Yes.

Female: Sure.

Female: Yes.

Gerri Lamb: OK.

Peg Terry: We have...

Gerri Lamb: I think we've gotten through the-- you know, we've attended to the goals, Peg, which was to get people a feeling for the process, to be able to hear from -- on the measure developers in terms of some common issues and to help them anticipate where we're likely to be going when we get together. Is there anything we're missing in terms of the goal for this meeting?

Peg Terry: I don't think so. We have a few next steps, but I do want to say this. Your -- the discussion today what we'll do Gerri is we'll get with you to make sure we have this time for discussion structured well with you. So, we're probably going to be putting the agenda together soon, so we'll be getting in touch with you. I think we have some time out there so we can make sure we're right on target, so we do have time to discuss these important issues.

Gerri Lamb: That would be great and I think Donald will be back next week.

Peg Terry: Terrific, terrific. So, I want to thank everybody, but I actually want to turn it over to -- if there's nothing else -- Gerri, I'll just going to turn it over to (staff here we ask some) next the steps for everybody.

Yetunde Ogungbemi: Thanks Peg. So, I'm just going to review the next step for the committee and the staff here. The committee members should continue reviewing the measure that's assigned and be sure to get your surveys completed by this Friday...

Christopher Dezii: OK.

Yetunde Ogungbemi: ...February 10th. Once those surveys are completed, the NQF staff will compile the responses and put them in the worksheet as you thought will -- as you all see here today or on tomorrow's call. The P.A.s will be updated and they will be put on the committee share point. We'll also send these P.A.s to the developers and put them on the NQF Web site. Tomorrow, we have workgroup call number two where we will discuss the rest -- the remaining measure, 0326 which is advance care planning and the two pediatric asthma measures.

The Standing Committee will convene at NQF offices in D.C. later this month on February 22nd to have our in-person meeting. And during that meeting, we will -- the standing committee will review and recommend the measures for endorsement, discuss and review the measure portfolio holistically. And depending on our progress during the in-person meeting, we'll determine whether we have the post-meeting call on March 7th or not. And I will turn it back over to Peg.

Peg Terry: OK, well, thank you.

Christopher Dezii: Just quickly, I don't have asthma measures in my list.

Yetunde Ogungbemi: And so this measure is 3170 and 3171. They are...

Peg Terry: They're to be discussed tomorrow. We do have a team ready to discuss them and they are on the Web -- on the committee side of the Web site.

Yetunde Ogungbemi: Each group has different people on it, so.

Christopher Dezii: All right. Then, do I need to get on the call tomorrow if I'm not in that group?

Yetunde Ogungbemi: No, you do not.

Peg Terry: Absolutely not.

Christopher Dezii: OK, unless I want to, right?

Peg Terry: Yes, absolutely.

Female: You're more than welcome to join.

Christopher Dezii: Yes.

Female: Just to clarify that the folks on this call are to review the four measures we discussed, just those four, correct?

Christopher Dezii: Yes.

Peg Terry: Right, that's right, and to give you really a sense of how the measures are look at and how we (review) at the meeting, yes.

Christopher Dezii: Just a quick note, I wanted to thank -- I haven't done this in a while and it's really nice to have the measure developers on. So, you know, I thank you for participating. Colby and Dr. Palmer and whoever else is one.

Samira Beckwith: So, is it four or five that we're going to review?

(Multiple Speakers)

Peg Terry: There are three measures for tomorrow.

Samira Beckwith: Right.

Peg Terry: And they -- Yetunde, who is this?

Samira Beckwith: I'm sorry, this is Samira. I'm just looking to the list again.

Yetunde Ogungbemi: So, there are four measures for review today and three measures for tomorrow but seven measures in total and each committee member is asked to be familiar with every single measure that we're reviewing for the project.

Male: That's correct.

Samira Beckwith: OK, thank you.

Peg Terry: Great. Well, thank you everybody and I think we have one more -- we have to open this to the public?

Female: Yes.

Yetunde Ogungbemi: Yes, so we will open up -- operator, could you open up the line for member and public comment?

Operator: Certainly. At this time, if you would like to make a public comment please press star one. Once, again, that is star one. We have no comments at this time.

Peg Terry: OK. Well, thank you very much and this has been a great call and I wanted particularly thanks Gerri for her guidance and her leadership here. It's been great and we'll be on the call tomorrow. So, look forward to that as well. Thank you everybody for your participation.

Gerri Lamb: Thanks everybody.

Female: Thank you.

END