NATIONAL QUALITY FORUM

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CARE COORDINATION STANDING COMMITTEE

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WEDNESDAY
FEBRUARY 22, 2017

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The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Donald Case and Gerri Lamb, Co-Chairs, presiding.

PRESENT:
DONALD CASEY, MD, MPH, MBA, FACP, FAHA, Co-Chair; Alvarez & Marsal
GERRI LAMB, PhD, RN, FAAN, Arizona State University
RICHARD ANTONELLI, MD, MS, Boston Children's Hospital, Harvard Medical School
SAMIRA BECKWITH, LCSW, FACHE, LHD, Hope HealthCare Services
RYAN COLLER, MD, MPH, University of Wisconsin-Madison
CHRISTOPHER DEZII, RN, MBA, CPHQ, Bristol-Meyers Squibb Company
SHARI ERICKSON, MPH, American College of Physicians
BARBARA GAGE, PhD, MPA, George Washington School of Medicine and Health Sciences
DAWN HOHL, RN, BSN, MS, PhD, Johns Hopkins Home Care Group*
MARCIA JAMES, MS, MBA, CPC, Mercy Health Systems*
EMMA KOPLEFF, MPH, Community Health Accreditation Partner
BRENDA LEATH, MHSA, PMP, Westat

RUSSELL LEFTWICH, MD, State of Tennessee, Office of eHealth Initiatives
LORNA LYNN, MD, American Board of Internal Medicine*
KAREN MICHAEL, RN, MSN, MBA, AmeriHealth Caritas Family of Companies
TERRANCE O'MALLEY, MD, Partners Healthcare System
CHARISSA PACELLA, MD, University of Pittsburgh Medical Center
ELLEN SCHULTZ, MS, American Institute for Research
JEFFERY WIEFERICH, MA, State of Michigan Behavioral Health and Developmental Disabilities Administration

NQF STAFF:
SHANTANU AGRAWAL, MD, President and CEO
HELEN BURSTIN, MD, Chief Scientific Officer
ANN HAMMERSMITH, JD, General Counsel
ELISA MUNTHALI, Vice President, Quality Measurement
MARCIA WILSON, PhD, Senior Vice President, Quality Measurement
KAREN JOHNSON, Senior Director
MARGARET (PEG) TERRY, PhD, RN, Senior Director
KATHRYN STREETER, MS, Senior Project Manager
MAY NACION, MPH, Project Manager
YETUNDE OGUNGBEMI, Project Analyst

ALSO PRESENT:
YVETTE APURA, PCPI Foundation
MARY BARTON, MD, National Committee for Quality Assurance
ELVIA CHAVARRIA, PCPI Foundation
DIEDRA GRAY, PCPI Foundation
LAWRENCE KLEINMAN, MD, University Hospitals Cleveland Medical Center
SHANA SANDBERG, PhD, National Committee for Quality Assurance

*** present by teleconference**

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P-R-O-C-E-E-D-I-N-G-S

8:41 a.m.

DR. TERRY: Good morning, everybody. We were just waiting for a few minutes, we were waiting for quorum and I guess we have it, so, welcome everybody to our Phase 4 of Care Coordination. And as we get started, I'm going to pass the baton here to our new CEO, Dr. Agrawal, and he's going to provide some opening remarks.

DR. AGRAWAL: Great, thank you. Well, thanks, everybody, for coming this morning. This is my first committee that I will get to see and experience live and in-person for myself, so I'm very excited about that. And I want to, in particular, thank Don and Gerri, they've been leading this effort for, I understand, over a decade now. Can we say care is coordinated, can we check the box?

(Laughter.)

DR. AGRAWAL: I will say, this is a topic, as an ER doc, that is actually really near

and dear to my heart. It's essentially important, I think it's really hard to do in the healthcare system generally, but I've certainly -- and it can be very hard to do from the emergency department, but where it works well, I think it has just tremendous impact on the lives of patients, on the experience that they have and the care that they get, and certainly can even dramatically reduce costs.

So, it is an extremely important topic and I'm just glad to be in the room and watching you all wrestle with it. The measures look very interesting. And I was also very heartened to see that there's a couple that are related to the ED. So, I think that's great. With that, I will hand it back. Unless there's any questions for me, by the way. I am in week four, so I know all the answers.

(Laughter.)

DR. AGRAWAL: Any questions you might have? All right, thank you.

DR. TERRY: Okay. If there are no --

any questions? No? Okay. I just want to introduce myself. My name is Peg Terry and I'm the Senior Director on this project. And I want to have the rest of the team here introduce themselves.

MS. STREETER: Hi, good morning. My name is Katie Streeter, I'm Senior Project Manager here at NQF.

MS. NACION: Hi, May Nacion, another Project Manager.

DR. TERRY: Thank you.

MS. OGUNGBEMI: Hello. I'm Yetunde Ogungbemi, Project Analyst on the Care Coordination Project. Welcome.

DR. TERRY: Thank you. Just a few housekeeping tips before we move over to the Chairs and to the roll call. So, just a few things. The restroom location, down the hall, to the right.

I think most people have figured out wifi, we've been having our tech people help you this morning, but there is information there on

the left and there's somebody in the hallway if you need some help.

We use these tent cards, which they call them, if you want to speak. So, you just -- if you want to speak, you put it up and people will -- you'll be recognized, if you want to talk on some particular issue. Up like that, yes.

And we're asking that you please mute your cell phones. If you need to take a call, we're asking you to go out in the hall and do that, not to do it in the room. So, with that, I'm going to turn it over to the Chairs, to first introduce themselves.

CO-CHAIR LAMB: Good morning, everybody. It is so nice to have every one of you here. We've all talked on the phone recently for a very long time. I thought it was absolutely wonderful preparation. Just a couple things besides welcome and then, I'll turn it over to Don.

One of the really wonderful things, not only are we focused on care coordination, but

we've got continuity here. We have been working on this a long time together and we have a really wonderful opportunity, I think, to continue to move the needle on a very, very important topic.

So, one thing, as we go around and do intros, before I forget, would you also share if you are on other NQF committees, because one of the things that Don and I have talked about with all of you in off-cycle is the ability to coordinate care coordination measurement across the board.

And one of the things that we'll be talking about, as we talk about gaps, is how to move that needle forward in terms of really looking at the portfolio in a meaningful way. So, if you could share that?

So, again, I'm Gerri Lamb. I have co-chaired this meeting, as Dr. Agrawal has said, for ten years now with Don Casey, who is probably -- and Helen just can't believe it over there. Yes, yes, okay, now that you've got that straight in your mind and you're not overwhelmed. We have

been doing this together and I could not ask for a better Co-Chair.

And I also hail from Arizona, as you all know, I'm at Arizona State University. And I also co-chair the Measures Application Partnership, Post-Acute Long-term Care, which is a nice bridge for care coordination. Don?

CO-CHAIR CASEY: Thanks, Gerri. I'm Don Casey. I'm a general internist by training. I live in Chicago. My bio is already out of date, so I apologize for that. I work for a healthcare consulting firm called Alvarez and Marsal, which does national work around a lot of the issues we're talking about.

And I'm also a member of two faculties. One is the Rush Medical College faculty in Chicago, which is where my training alma mater was. And I also teach at the Jefferson College of Population Health. In fact, I'm teaching an online course right now, a 14 week masters level course on quality and safety through Jefferson, and that's been interesting.

I guess we didn't get to put a shout-out to our colleague, Helen Burstin, but Helen's been a great, great leader and resource for NQF. And it's so good that we have the chance to work with you, Helen, because you've done so much great work and we know this is one of your major issues.

And I also want to say to Katie, May, and Yetunde that if you don't know, I've witnessed over the past years a number of great Staff people that have come into the Care Coordination Steering Committee.

So, by right, since they're all relatively new to this Committee, it's kind of a new rite of passage for them. They've arrived at NQF by being part of this Committee. So, thank you very much. And I do not currently sit on any committees right now within NQF.

CO-CHAIR LAMB: Thank you.

MS. HAMMERSMITH: We're going to combine introductions with disclosures, because it's quicker.

CO-CHAIR CASEY: And I have no relevant relationships with industry or disclosures to make today.

CO-CHAIR LAMB: And I think I put this on my COI, but I serve as a consultant to NCQA on measure development, but none of them are coming forward.

MS. HAMMERSMITH: Okay, thank you. You've got very experienced Co-Chairs, so they know the drill. I'll go through it, just to refresh everybody's memory and help new Members understand how we do this. So, I'll just give you a snapshot of the conflict of interest disclosure process.

You all got forms when you applied to be on the Committee, which were reviewed by Staff. Those forms are part of the consideration for putting you on the Committee, because we don't want to put someone on who has so many conflicts that they wouldn't be able to participate very much.

So, that's an initial screening. So,

what we want to do at this public meeting is have you go around the table and tell us if you have anything to disclose.

A few reminders. You sit as individuals, you don't represent your employer, you don't represent anybody who may have nominated you on the Committee. Occasionally, people will say, I'm Joe Smith and I'm here representing the American Academy of Fill-in-the-Blank. And, actually, that's not correct, you sit because you're an expert.

I also want to remind you that just because you disclose does not mean you have a conflict of interest. Part of the point of doing this is full transparency and so that people have some feel of where you might be coming from. So, just because you disclose does not mean you're conflicted.

We are particularly interested in your disclosure of relevant speaking engagements, research, and grants. If you have other things you want to disclose, please feel free to do so,

but we are particularly interested in those items.

Relevant means it has to do with care coordination, it has to do with the subject matter before the Committee. We know that you all have distinguished resumes and we don't want you to disclose every single thing on your resume.

The other thing that's unique about NQF's disclosure process is we're not just considering financial disclosures. Again, occasionally we'll have people say, I have no financial disclosures, I have no financial conflicts, which is great, but we also look at relevant activity that you may have done as a volunteer.

So, for example, you may have sat as a volunteer on a committee for your professional society on a topic that is relevant to what you're doing today. Doesn't mean it's a conflict, but we would ask you to disclose that.

So, your Co-Chairs have already done

this, but let's go around the table, tell us who you are, who you're with, what NQF committees you have been on, and if you have anything to disclose.

MEMBER ERICKSON: Hi. I'm Shari Erickson with the American College of Physicians, one of the few locals other than the Staff here probably. And I do government affairs and I also run our medical practice support area.

And I, in terms of disclosures, I do a lot of writing of our policy from ACP's perspective, with regard to measurement in reporting programs for CMS and other payers. But I don't know if that's really a conflict, just something that I should probably disclose. And a former NQF Staff member as well, yes.

MEMBER PACELLA: I'm Charissa Pacella. I am with the University of Pittsburgh Medical Center. And I have an operations leadership role in oversight of four emergency departments in an integrated delivery system. I have not participated before with an NQF task force and I

have no conflicts to disclose.

MEMBER DEZII: Hi, guys. Chris Dezii, Director of Healthcare Quality, Bristol-Meyers Squibb. It's my second career, my first career, I ran a kidney/pancreas transplant unit in Hahnemann University Hospital in Philly for a while. No conflicts.

I did some adherence work with NQF in measures, I don't remember, a while ago. Just came off the MAP's Coordinating Council, representing PhRMA. Just finished -- this isn't a conflict or -- I'll throw it out there. I'm active in the Pharmacy Quality Alliance, just came off their Quality Metric Expert Panel, term limited.

And I was named co-chair to the ACP's Healthcare Round Table yesterday, so I'm pleased with that. No disclosures. Oh, and I'm also very active, like to think I'm very active in supporting the Incubator Project. Thank you.

MEMBER SCHULTZ: Hi. I'm Ellen Schultz with American Institute for Research. I do a

range of quality research, everything from program evaluations, I have one right now around care coordination, and also developing measures and applying measures to various quality areas. I don't have anything further to disclose beyond that.

MEMBER COLLER: I'm Ryan Coller with the University of Wisconsin. And I apologize for any sniffling or coughing, I caught my youngest daughter's cold and pretty much the cold of every patient I've taken care of for the last week.

So, I'm a general pediatrician, I work inpatient and outpatient, and am Chief for our Hospital Medicine Group in Pediatrics at the University of Wisconsin.

My other focus that's relevant as a disclosure is that I work with children with medical complexity in a care coordination program that we have and my research is on trying to identify and prevent hospitalizations for this population. I don't have any conflicts. I'm new to the Care Coordination Committee and looking

forward to becoming a part of the journey.

MEMBER MICHAEL: Good morning. My name is Karen Michael. I'm the Vice President for Corporate Medical Management with AmeriHealth Caritas. And this will be the coughing side of the table, I picked up a wonderful sinus infection on my way back into the country yesterday. Don't have any jet lag at the moment, so hopefully I'll be able to stay awake for the entire meeting today.

I don't have any conflicts or relationships with any measure creators or endorsers. We use a lot of the different measures throughout all of our work across the country, so I'm very happy to participate in efforts to help standardize those, because a lot of the ones that the states develop on their own need a little work. So, this is very important work. Thank you.

MEMBER KOPLEFF: Hi. My name is Emma Kopleff. I've had the privilege and am thankful to have been part of the NQF tables for some

time. First, under Helen and her team's tutelage as an NQF employee many years ago.

In more recent years, with a national consumer advocacy organization, and now I join you representing myself as Ann notes, but currently I work for Community Health Accreditation Partner.

I have no conflicts to disclose, but, again, thankful to be here as CHAP, my employer, is looking to propulse on the forward-looking future of measurement as we revise our standards for accreditation.

MEMBER ANTONELLI: Good morning. I'm Rich Antonelli. I'm a general pediatrician and I'm also the Medical Director of Integrated Care at Boston Children's Hospital. I am on the MAP Steering Committee and then, also, the Medicaid Child Task Force, the Chair of that here at NQF. I don't have any conflicts to disclosure, except that everybody hates the New England Patriots.

(Laughter.)

MEMBER ANTONELLI: Except possibly

Terry.

MEMBER O'MALLEY: Yes, hi. Terry O'Malley, I love the New England Patriots. That's my only disclosure.

(Laughter.)

MEMBER O'MALLEY: I'm a general internist and geriatrician and former Medical Director of Non-Acute Care Services for Partners Healthcare in Boston. And sit on one other NQF committee, the Interoperability Project, which is going to be interesting.

I'm a member of the Federal Health IT Standards Committee and I'm the Community Lead on the ONC S&I Framework Electronic Long-Term Services and Supports Work Group. And, finally, a board member of Long-Term Quality Alliance.

MEMBER GAGE: Hi. I'm Barbara Gage. I'm a research faculty at George Washington University and have been working on quality measurement and care coordination for many years. I, in the interest of disclosure, and I don't think it's a conflict, I do much of my work for

CMS on helping develop quality measures in the past, but in the past five years, have been working more in developing data elements to meet the requirements of the IMPACT Act.

So, I'm often collaborating with quality measures and former colleagues at RTI. I'm a RAND affiliate faculty member as well. And we are doing so more on data development for med reconciliation, so I'm very interested in that discussion, but we are not developing quality measures in that area. Thank you.

MEMBER WIEFERICH: Good morning. I'm Jeff Wieferich. I currently work for the State of Michigan and oversee the Public Behavioral Health System and the Medicaid services that are delivered in that system. It's my first involvement with NQF, in any large standing committee. So, I have nothing to disclose and no conflicts.

MEMBER BECKWITH: Good morning. I'm Samira Beckwith and I am the CEO of an organization in Southwest Florida that includes

many post-acute and pre-acute services, hospice, home health, PACE, CCE programs, Parkinson's programs, Alzheimer's programs, just a number of programs for people with serious illness to coordinate their care and hopefully provide them with the best quality of life during their time with our organization and under our care.

I don't have anything relevant to disclose in terms of a conflict. I'm just very interested in this topic. My first NQF official committee, I've followed the work and, of course, attended meetings over the years, but never been this involved. Thank you.

MS. HAMMERSMITH: Okay, thank you. I'm going to call on the people who are on the phone. Colby Bearch? Colby Bearch, on the phone? Dawn Hohl?

MEMBER HOHL: Good morning. This is Dawn Hohl. First, I really want to apologize not being there in person, I had a bit of a family emergency arise. So, I'm delighted that I have the call-in option, so thank you much for that.

I am the Director of Transitions for Johns Hopkins Home Care Group, which really means I oversee the home care coordination of all home-based services for patients exiting any of the Johns Hopkins hospitals and affiliates. And that includes transitional level services. And I also oversee patient experience as well.

I've been with Johns Hopkins for 14 years and prior to that, was with the University of Maryland. I am from the Washington, D.C. area, so I'm close by. As it relates to disclosures, I don't believe I have any disclosures or conflicts. And I was involved in one prior NQF initiative on disparities with home care. So, thank you. Good morning.

MS. HAMMERSMITH: Okay, thank you. Marcia James? Is Marcia James on the line? Lorna Lynn? Is Lorna Lynn on the line?

MEMBER LYNN: I am on the line, but hardly able to speak.

MS. HAMMERSMITH: Oh, dear. Okay. We won't make you talk unnecessarily. Is there

anybody else on the phone I've missed?

MEMBER LEATH: Yes, this is Brenda Leath on the line. And I am from Westat.

MS. HAMMERSMITH: We're having difficulty hearing you.

MEMBER LEATH: Just a moment, please. Is this better?

MS. HAMMERSMITH: A little bit.

MEMBER LEATH: My name is Brenda Leath and I'm a Senior Study Director at Westat. I'm also the Executive Director of the Pathways Community Health Certification Program and I'm pleased to be here. I am not on any other NQF committees.

MS. HAMMERSMITH: Do you have any disclosures you'd like to make?

MEMBER LEATH: Just that I am the Executive Director of the Health Certification Program.

MS. HAMMERSMITH: Okay, thank you. Anyone else on the phone? Okay. Thank you for those disclosures. Before I leave you, I just

want to ask for your continued cooperation in our disclosure of interest process.

If you think that you have a conflict, if you think a Committee Member has a conflict, or if you think that someone is behaving in a very biased, unproductive manner, we ask you to bring that to our attention in real time.

What we really don't like to see is to have a Committee Member pop up two months down the road and say, you know, I think I may have had a conflict of interest. So, if you think you do, you're not sure, you can go to your Co-Chairs, you can go to NQF Staff, and it will be resolved. Any questions?

CO-CHAIR CASEY: Could you just clarify again, when it comes to voting, if it comes up, oh, I didn't even think of this, the process is to then recuse yourself from the voting for that particular measure, correct?

MS. HAMMERSMITH: Actually --

CO-CHAIR CASEY: Or is it the Committee?

MS. HAMMERSMITH: The way -- I'll tell you how it should work in a perfect world. Hopefully, you realize up front if you have a conflict, so then you recuse yourself from discussion and voting.

A lot of times, where the influence comes in or the perception of influence is in the discussion, it's not really the voting. So, if you get through the discussion and then, right before the vote, you think, oh, I think I may have a conflict, then that person would abstain, would just abstain from voting.

CO-CHAIR CASEY: Thank you.

MS. HAMMERSMITH: Okay. Anything else? Okay, thank you, have a good meeting.

DR. TERRY: Now, we're going to turn the meeting over to Gerri and Don, who are going to make some comments. Thank you.

CO-CHAIR LAMB: Before we get into reviewing measures, which we'll be doing in some depth and that's really the crux of our work together, Don and I would like to just give a

little bit of context, especially for those of you who are new, that we're delighted you're here.

This Committee has, as you've heard, has a history and so, we thought it would be helpful to have background as we move into consensus development, the CDP process, as well as we will have time to talk about measures gaps.

I think we had some very rich discussion about that on the telephone calls as we were talking about the measures, in terms of, here's the measures, where is care coordination measurement going?

So, I'm going to give just a little bit of background, of history. We have a lot of people in the room who have been through that history, so that we will also have a chance, if there's some short things you'd like to say to add to setting some context before we move into CDP, we will have the discussion of gaps.

So, I'm going to give a little bit of background and then, turn it to Don, who is going

to talk a little bit about off-cycle work that we've done in terms of moving the needle on care coordination measurement.

As Standing Committee Members, we have the wonderful chance, not only to do CDP, the measurement review of maintenance measures and new measures, but also to craft the measurement of care coordination, which, as everybody has been saying, is so integral to the quality and cost of healthcare.

So, just a few words about background, again, from a context setting, and then, I'm going to turn it over to Don to talk about kind of next steps. So, history wise. As you've heard, this Committee has been in place for a number of years. I want to just give you some benchmarks on that.

We're very fortunate that the NQF Staff has also archived and created a summary of this history that will be shared with all of you as well. One thing that I'd like to share is, none of the comments that you made in terms of

gaps have been lost, they're in that summary, so we'll have kind of a go-forward in terms of our work together.

So, even though we may not get together a lot face-to-face, we have a chance to do online work together and also, not only review measures, but, again, move things forward. So, history wise, just a couple of key points.

And these documents, many of them are in our SharePoint, so I would, if you haven't read them, I think they would give you very good background. That goes for new Members, as well as Members who are here on an ongoing basis.

So, in 2006, okay, remember we're in 2017 now, there was the initial model development and an initial definition of care coordination. And if you move forward, that definition has been added to, refined as we've gone along. So, 2006 was the initial model and definition. I believe Don was part of that work, I was not. Anybody else in that 2006 group? Rich was, okay. So, we have historians in the group.

In 2008, we moved into measure review and also looked at preferred practices. And as I'm sure Don will remind you, because Don is a believer in the preferred practices driving measurement, is to go back and look at that. And you will have a list of all of the preferred practices that have been put forward to this group.

So, that was 2008. And interestingly enough, a lot of the focus back then, not surprisingly, was on transitional care. That was kind of that growth period, when we were looking at quality and cost in the recognition that hospital admission/readmission, ED visits, were something that we could make an impact on, care coordination with measurement.

So, a lot of the early measures, if you go back and look at them, are focused on transitional care. A lot of that time, and you'll see as we come forward to the new measures today, that at that time, we were dealing with, could we get something out there that began to

look at the connects in the system?

And what you saw a lot in those early measures is, did somebody make an appointment? Did you leave the hospital and was an appointment made? And as many of you said on the call, was it last week, last week, is, is that enough? Is it enough just to make an appointment? And that discussion was, well, what happens then? Was the appointment kept? What happened during that appointment?

We've had lots of those discussions, if you go back into some of the reports, and they're very lengthy reports from this Committee that are on SharePoint, where we try to capture that dialogue of, was that enough?

So, we're fast-forwarding, then, to 2014, where there was a Measure Gaps Committee. NQF really has put a lot of emphasis and resource, and I would just like to echo Don's comment, is Helen has been through all of that with this Committee, in terms of assisting us to move forward in terms of measure gaps and really

begin to capture what that process and outcomes, not so much the structure, but structure is there as well.

In 2014, and I would strongly encourage you to look at this, is the definition of care coordination that would drive measurement was updated, there were a lot of new pieces, lots of discussions about outcomes, synchronicity, synchronization, patient involvement.

So, as you saw the triple-aim move forward, you also saw the adjustment in the definitions, as well as the framework. And a lot of work went into that framework, lot of passion and clinical knowledge, research went into the definitions and into the new framework that now guides our measurement.

So, at that time, in terms of historical kind of steps, landmarks in care coordination measurement, we saw the addition of concepts like the plan of care and that the patient needed to be engaged. What a revelation, huh?

Synchronization, teamwork, outcomes, all of that came into the framework and definition in 2014. Interestingly though, and Don will address this in his comments, is we began to see fewer measures coming forward.

In the beginning, we saw a lot and it was -- while they were somewhat early on, somewhat primitive in terms of what we understand care coordination to be now, we had a lot of movement, but we've had very few measures. So, it's really a wonderful step that we have new measures coming forward and that becomes part of our measures gaps.

We've had in off-cycle, those of you who have been involved in off-cycle, you know that we really have wanted to continue that dialogue. How do we keep those measures coming? How do we begin to capture that framework?

And so, 2015, 2016, the off-cycle work has really been about future directions, how do we encourage, engage better measurement of care coordination? And I'm going to stop there and

turn it over to Don to take it to today.

CO-CHAIR CASEY: Thanks. Before I do, I wanted to waive out to Brenda, who is on the phone. Brenda, thank you for getting here today, this is great. So --

CO-CHAIR LAMB: That was fast.

CO-CHAIR CASEY: -- it's great.

(Laughter.)

CO-CHAIR CASEY: I could tell she was getting -- she was on her way. Yes, let me say a few things quickly. One is, it would behoove you all, the people that have been on this Committee for more than one cycle have seen the preferred practices, but it would behoove you all to go back to those and stare at them. We've revised them too.

And I guess the way I would highlight the preferred practices was that, we came to a junction, I think, Helen, in the first cycle where we had something like 70 measures, but a lot of them were like, I faxed the dermatologist a copy of the melanoma report.

And we thought that was a good measure at the time, but we didn't think it embodied the notion of what real care coordination was about. So, it wasn't that it wasn't important, the problem we were trying to solve was a lot bigger.

And, as you know, all of you, there are tons of moving parts to care coordination, whether you live in a world where that's the focus of what your job is or whether you have personal experiences with your loved ones or even yourself in trying to do this, which I'll talk about.

But it was at that point that we really sat down in a room with a lot of smart people and tried to codify all the moving parts. And I think we got it pretty right the first time, there's obviously a lot of change, for example, in the evolution of health information technology, as one example of what we're focused on.

But really pay attention to those, because I think it will help guide your vision

about what we're trying to be aspirationally. As Gerri mentioned, a lot of these measures have been traditionally brought forward by measure developers as, what I would call, transactional measures.

I read a great book on the Battle of Waterloo and Lord Wellington, who led the British forces, was quoted as saying, just because the message has been sent doesn't mean it's been received. And I think that's a pretty good mantra for thinking about what we're trying to accomplish. We send a lot of messages out there and, especially when it comes to the patient, that's a challenge.

And the other thing that happens, I think, with newer Members is they get -- they see the big picture, they know where we want to go, and then they see these smaller crafted measures and they sort of think, let's get bigger, let's push the envelope, this isn't fast enough or good enough.

And I would say most of the measures

we've endorsed in this Committee are what I would call necessary, but by no means sufficient. And so, we have that as our moniker as well of understanding, that we understand that we're building blocks to get to where we want to go.

And we've given a lot of challenges, which we will do today, to the measure developers about this as well and given them strong feedback about where we think they ought to be going, especially when it comes up for measure maintenance, so that's important.

But the last thing I'll say is, I just lived through a couple years of being primary care coordinator for my dad, who I visited yesterday in Arlington National Cemetery. And so, this is very personal for all of us and it's a big challenge.

I was amazed, because he was at the VA, Northwestern, Presence Health, he had doctors everywhere, a nephrologist, a dermatologist, and if it wasn't for me, I don't think he would have figured it out. But the important thing is that

he ended up in the right spot. We coordinated that care too, which is good.

So, thank you all for being here. And just as a reminder, the people on the phone, message Katie and that will be putting your hand up if you want to make a comment. I think right now we just have Colby.

MS. STREETER: And Lorna.

CO-CHAIR CASEY: And Lorna, sorry Lorna. So, we know you're here, so we're ready to go.

CO-CHAIR LAMB: Okay. So, we're going to move now into consensus development and we're going to go into measure review. And I'm going to turn it back over to Peg.

DR. TERRY: I think that we'll talk a little bit about the voting first.

CO-CHAIR LAMB: Okay.

DR. TERRY: So, Katie?

MS. STREETER: And, just a refresher, we did talk about this in more detail during the orientation and Q&A calls, but for roles of the

Standing Committee, you all act as a proxy for NQF's membership.

As such, this multi-stakeholder group in the room brings varied perspectives, values, and priorities to the discussion. Respect for differences of opinion among Committee Members and measure developers are expected.

Today, only the new Members joining us will be selecting two or three year terms, as most of you have recently renewed your term with the Committee. And we'll do that probably during lunch.

So, ground rules for today's meeting, I won't read this slide off word-for-word, but please be prepared, having reviewed the measures beforehand. I think our work group calls that we held a couple weeks ago really helped us prepare for the discussion and the review today.

Please base the evaluation and recommendations on the measure evaluation criteria and guidance. Remain engaged in the discussion. Attend the meeting at all times,

except at breaks. Keep comments concise and focused. Avoid dominating a discussion and allow others to contribute. And indicate agreement without repeating what has already been said.

So, the process for measure discussions. We are very fortunate to have our measure developers with us today. They will be having a seat at the table.

They will begin by introducing the measure with a two to three minute introduction and then we'll turn it over to the lead discussants, who will begin the Committee discussion by providing a summary of all of the comments that everyone submitted and also emphasizing areas of concern or differences of opinion as each evaluation criteria is discussed.

The developers will be available at the table to respond to questions at the discretion of the Committee. And then, the Committee will vote on each criteria and subcriteria. Is there any questions with the process for today's measure review? Okay.

MS. OGUNGBEMI: Good morning. And I'm going to review the endorsement criteria and voting. So, the criteria are listed in a specific order of hierarchy and there's a logic to looking at them in the order in which they are listed.

The first one will be importance to measure and report, followed by scientific acceptability to measure properties, which includes reliability and validity. The first two criteria are must-pass, and that's evidence, gap, reliability, and validity, so it's two, but also four.

Note that we will discuss harmonization and best-in-class after the PCPI measure discussion. Subcriteria delineate how to demonstrate that the measure criteria are met.

NQF's process focuses on achieving consensus. Our consensus guidelines state that greater than 60 percent of a committee must vote in support of a measure to have it pass. Sixty percent of our 21 members is 14, so we do have

quorum today. So, 14 of those members must vote yes on high or moderate for a pass or a recommendation for a measure to be endorsed.

Between 40 and 60 percent of the Committee, inclusive, is consensus not reached, or a grey zone. Regardless, these measures continue forward, but are flagged as consensus not reached.

If a final vote is consensus not reached, this measure goes out to comment, comments are requested and reviewed, and the Committee will revote on a post-comment call. Below 40 percent does not go forward. So, that's if less than or equal to eight votes, the measure will not go forward. Are there any questions?

CO-CHAIR LAMB: So, the only options in voting are pass or not pass?

MS. OGUNGBEMI: And consensus not reached. But if -- I will go through the actual criteria in voting later on. Right before we start actually clicking and voting, I'll give you a high, moderate, low, insufficient.

CO-CHAIR LAMB: When people vote, it's either thumbs up, thumbs down? Okay. So, please explain.

MS. OGUNGBEMI: Well, I have a presentation later on, yes.

CO-CHAIR CASEY: All right. So, we're going to start off with measure 0326. And that is the Advance Care Plan. The Stewart is NCQA, I assume we have our NCQA representative here. There she is, okay, good. Thank you. Our lead discussants will be Shari, Jeff, and Lorna will be our secondary discussant.

This is a process measure, based upon the discussion that you had and the feedback that you submitted, thank you very much for being here. This is, briefly, the percentage of patients aged 65 years and older who have an advance care plan or a surrogate decision-maker documented in the medical record or documentation in the medical record that an advance care plan was discussed, but the patient did not wish or was not able to name a surrogate decision-maker

or provide an advance care plan.

So, it has this additional ability for documenting the presence of the advance care plan. I'm not going to read through all of the specifics, because I know that you've been through this before.

In our preliminary discussions, the group felt that the evidence supporting this was of moderate quality. The gap was considered by the group as being moderate, based upon the information that we discussed. Reliability was moderate. Validity was moderate. And Feasibility, moderate. And usability and use, moderate.

Now, these are qualitative words that have, just as a reminder, some imprecisions in them, but are meant to capture the spirit of the discussion. We do have, obviously, within the criteria guidance about what we mean, but we're trying to, as a group, sort of come to an understanding together. So, that's the background on this. And --

MS. MUNTHALI: Hi, sorry, Don. We just wanted to give the developers two to three minutes for an introduction of their measures. And just one point of clarification, for the maintenance measure, as Don mentioned, this measure has been brought in front of us, the Committee has an option under our new maintenance process to accept the evaluation of the previous Committee, which you chaired, for Evidence.

Performance gap, we'll ask you to vote again on that. Testing, if there are any differences in testing for reliability and validity, you'll have to vote on, but if there are no changes on reliability, you can accept the previous discussion on that. We also want you to vote on Feasibility and Usability and Use as well. So, thank you.

CO-CHAIR CASEY: And I know Yetunde will guide us through that process as well, because you're voting on all these things together as we go through this. So, I'll let the measure developers have a couple minutes to give

us your thoughts and impressions.

DR. SANDBERG: Thank you. My name is Shana Sandberg, I'm a research scientist at the National Committee for Quality Assurance. I'm here today with my colleague, Dr. Mary Barton, who is Vice President for Performance Measurement at NCQA. We're very pleased to be here today.

As Dr. Casey explained, the measure we're discussing is NQF 326 Advance Care Plan. And, briefly, this measure requests reporting of the percent of patients age 65 years and older who have an advance care plan or surrogate decision-maker documented in the medical record or documentation that an advance care plan was discussed, but the patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan.

This is a maintenance measure, it was first endorsed by NQF in 2007, and it was last reviewed by the Committee in 2012. The intent of this measure is to encourage advance care planning discussions between providers and

patients.

Stakeholder groups representing the National Academy of Medicine, the National Quality Forum itself, and other prominent groups have highlighted advance care planning as a key component of high quality healthcare.

Numerous studies demonstrate a relationship between advance care planning and other markers of healthcare quality, including decreased hospitalizations and decreased lengths of stay.

This measure has been used in the CMS Physician Quality Reporting System and is also used in its successor now, the Quality Payment Program. Performance on this measure indicates that a quality gap still exists.

Among those providers who choose to report performance on this measure, the average performance rate for 2014 was about 67 percent, indicating that among reporting providers, almost a third of Medicare patients did not have documentation of an advance care plan, surrogate

decision-maker, or an indication that they didn't want to discuss it. So, NCQA believes that this documented performance gap demonstrates the continued need for this measure.

One other issue that I wanted to address before we open the discussion, because it came up in comments from the Committee, in 2016, CMS did issue new billing codes to reimburse providers for advance care planning. These were not in use at the time that the measure was developed and, therefore, are not in the specification.

However, we do feel that these codes meet the intent of the measure and we will be seeking to speak with our contacts at CMS to raise the possibility of incorporating these into the accountability measure and to change the specifications. So, we thank the Committee for those comments.

CO-CHAIR LAMB: Okay. We're going to move now into review. Shari, you're lead on this? Oh, okay, so you've decided on that, all

right. We're going to go through -- Jeff, good for you.

What we're going to do is follow the discussion guidelines, please. Everybody should have a copy of that. We're going to go through each criterion, stop, okay, have a discussion, and then move on.

So, what we'll do is, each of our identified discussants will, the lead will talk first, then the other two folks will have a chance to add anything, you don't need to repeat it all again, just add anything that hasn't been said. And then, we will open it up to discussion, vote, and then move on to the next criterion. Okay. So, Jeff?

MEMBER WIEFERICH: Okay. Thank you for the introduction of the measure. I'm assuming that what I can do is move on to the evidence portion? Okay. This is a maintenance measure and it is a process measure, as has been identified.

The information submitted, there was

not any new information since the original evidence was last evaluated. The previous information talked about a systematic review completed by the National Hospice and Palliative Care Organization.

And in the studies, the developer notes a positive correlation between quality efforts to increase advance care planning and the compliance of end-of-life care. It provided some updates regarding the systematic review from the Palliative Care Medical Journal, the effects of advance care planning on end-of-life, a systematic review.

Another developer -- or the developer cited a systematic review added to the evidence designed to review and evaluate evidence, but not to grade or provide a recommendation. One hundred and thirteen studies were included, 95 percent observational, five percent experimental.

Twenty-six evaluated for the effects of advance care planning on hospitalization and length of stay. Twenty-one concluded that it was

linked to a decrease, five others concluded the opposite. Thirteen studies evaluated whether or not ACP has an effect on patients and family symptoms. Five concluded they decreased, but none found they increased.

They indicated no new studies have been conducted that dispute the conclusion of ACPs as a critical piece of high quality patient care. Five percent are a Grade 1, 59 percent are a Grade 2, 36 percent of the included studies received a Grade 3.

In terms of some of the comments that we received regarding this, the comments did support that there was a moderate -- all supported moderate agreement. They did not believe that we needed to revote on or that there was a need for a rereview of more information. We did have one individual point out, there's a number of new and old studies that were not cited by the measure developers.

I don't know if that's something that -- the developers cited one systematic review

with inconsistent evidence, no other linkages are important to outcome, such as avoidable hospitalizations and ED visits, ICU utilization, referrals to the hospice, increased use of palliative care services, family and caregiver benefits, and declines in end-of-life related issues.

Another comment regarding that was, there's no standard definition of the necessary components of advance care planning. And the baseline, follow-on measures were from 2012 and 2014, which occurred before the CPT codes that were mentioned earlier. I'm going to stop there. Hopefully I'm going in the right manner that you need.

CO-CHAIR CASEY: Yes, and other Members who were involved with this review, want to add anything so far?

MEMBER ERICKSON: I don't have anything to add with regard to the Evidence. I know we'll be discussing the gap piece separately, correct?

CO-CHAIR CASEY: Right.

MEMBER ERICKSON: Okay. And I agree with the assessment Jeff gave.

CO-CHAIR LAMB: Lorna, we know you're online and if you're not able to talk with us, if you could write in any comments that you wanted to share? Is there anything from Lorna? Okay.

MS. STREETER: Lorna did note she has nothing to add.

CO-CHAIR LAMB: Oh, good. Thanks, Lorna. We miss you. And kudos to the first review for Jeff, so, yay Jeff. So, let's open it up. We do have -- we can either decide that we don't need to talk further about Evidence and whether to vote on it. So, any comments from anybody on the Evidence review? Okay.

MEMBER BECKWITH: Yes, just to clarify, are we voting that we believe there's enough evidence to continue the measurement?

CO-CHAIR LAMB: Yetunde, can you clarify that?

MEMBER BECKWITH: Yes, when we come to vote.

MS. MUNTHALI: Yes, I can take that. So, because it is a maintenance measure, the evidence hasn't changed. You can put a motion on the table that we accept the Evidence from the prior review. And it sounds like that's where the Committee would like to go.

CO-CHAIR LAMB: Samira, would you like to put that on the table?

MEMBER BECKWITH: Oh, I'll make a motion that we accept the Evidence and no change in the measurement review. I don't think I worded that correctly, but if you'd like to help with that wording, I would accept that help.

MEMBER WIEFERICH: And I'll second that.

CO-CHAIR CASEY: Any discussion? I would just like to point out in this discussion that we did provide two additional, more timely systematic reviews to the measure developers who had not incorporated that in their initial submission. So, we would hope you would take that into account.

And, by the way, if you're done speaking, turn your mic off, okay? It's got a red light on it. All right. Because we get feedback. Thanks.

CO-CHAIR LAMB: We passed it and we can move on to the next. So, Jeff, are you doing the next one too?

MEMBER WIEFERICH: Yes.

CO-CHAIR LAMB: It's Opportunity for Improvement. Okay.

MEMBER WIEFERICH: Okay. This is in regards to the performance gap. It does appear evidence was provided regarding some measures with this -- regarding some information with the measure.

They had 3,309 eligible professional continuously reported performance rates from 2012 to 2014 and it showed an improvement rate of four percent from 2012 to 2014, from 62.3 percent in 2012 to 67.2 percent in 2014.

The developer indicates there's no stratification of the measure by patient groups

or cohorts that could be affected by disparities in care, though they, the NCQA, has worked with the Institute of Medicine and others in an attempt to include disparities information. Currently, data is not coded in a standardized way and there isn't a standard entity designated to capture and report this partially captured data.

Some of the comments that we had regarding the performance gap. It did appear to be consistent and there was participation over time. It does seem to point to improved outcomes. Data were provided on the gap in care that appears to warrant a national performance measure.

The measure does not yet include disparities information, developer notes that they have begun working on how to do this. Inclusion of a means of identifying disparities in populations who have an advance care plan would significantly strengthen this measure. And that was rated as moderate in terms of meeting

the criteria.

Evidence supports a measure gap both in process being measured and in related outcome of having preference concordant care end-of-life. While the developer state no disparities could affect the measure, they may wish to consider whether disparities in having a usual doctor source of care might be associated with disparities.

And another comment was regarding the baseline and follow-on measures applied may be substantially increased with the institution of the CPT codes by Medicare in 2016.

MEMBER ERICKSON: No, I don't have anything to add. I mean, I think the main issues for consideration are really related to the disparities and the lack of disparities information, which I understand the challenges therein, but it's, I think, an important note for the developers to take back.

And also, and this really gets more at the -- a little bit later, when we talk about

reliability and validity, that we see with regard to the new CPT codes and their impact on being able to determine what the performance gap is here. I think that's pretty important.

CO-CHAIR LAMB: Any comments from Lorna?

MS. STREETER: I'll comment for Lorna. Regarding the performance gap, while it would be desirable to have information on disparities, there is sufficient evidence to support that a gap still exists and the lack of information on disparities does not change this.

CO-CHAIR LAMB: Let's open it up for discussion. Comments?

MEMBER SCHULTZ: So, I think I brought this up in our Work Group discussion about, I really can see some additional value in this measure by being able to look at whether a patient has a regular source of care already.

I don't think that that fundamentally changes its value, but I think it would be particularly interesting to be able to look at

across a population, for example, and identify groups of people who are especially vulnerable to lacking various aspects of care coordination and who might especially benefit from some additional outreach. And maybe that begins by just helping them find a particular source of care.

CO-CHAIR LAMB: Any other comments? Thanks, Ellen. If you would, just remember to put your, yes, put your name plate up before you talk? Terry?

MEMBER O'MALLEY: Thanks. I actually have a question. And that is, how closely linked is this particular measure with the CMS new payment codes for this activity? Because it seems to me that that's really a critical nexus and if we nail that, then this measure is flying and if we don't, then it's going to be hurting for a long time. So, I would say, focus very diligently on that connection, because that's key.

CO-CHAIR CASEY: I know preliminarily that there was modest usage of this code in the

first fiscal year, not more than about 15 percent, but we'll see, because it takes time and it was just instituted in 2016. So, I think we agree. Samira?

MEMBER BECKWITH: I think this is a very important measure. And it seems to me like there is still a very large gap in terms of understanding what is in the advance care plan, because they vary so much.

And also, I think this disparities piece is so important, because is it a large group of people or different illnesses, ages, socioeconomic backgrounds, people without a primary caregiver, et cetera, that don't find a way to access this and to be able to benefit from it?

So, not knowing exactly what we do hear, but it seems to me as though there's still a great gap in being able to understand or fully implement this to make it positive for more people.

CO-CHAIR CASEY: So, Samira, if I hear

you, I think what I'm understanding is, there needs to be more clarity about what we mean by an advance care plan. And just continuing to refine that clarity and trying to define better and better the components, which I think to some extent is dealt with a little bit by the presence of the CMS payment policy, but it's something that I think you'd like to see more ongoing work on in terms of precision. Is that right?

MEMBER BECKWITH: Yes, absolutely, because just the way the question is asked, to so many people, it is, they don't even -- yes, I have one. Well, what is in it and what does it mean?

And then, also, I think the comment that was made earlier about the fact that many people aren't even being asked if they don't have an ongoing physician or care coordination program that they're involved in.

Whether it be something like PACE or medical home or independence at home or something like that, it doesn't even really matter, because

they're going to go on to the next provider who is not going to even have a conversation.

MEMBER GAGE: I'd like to also underscore the importance of the measure. And, as Shari said at the beginning, this -- a lot, much of the work on care coordination is developmental and this is a really good starting point for just identifying the extent to which people are discussing these issues and documenting it, which is really important.

While Terry referred to the physician payments, it's also an issue in the post-acute care world. And it seems in the reviews that I've been involved in, there's pretty heavy consensus that this is a good starting point.

MEMBER O'MALLEY: And just a follow-up comment. I think this is a critical measure and really hugely valuable. And so, kudos to the group for pushing it forward. A lot has changed, though, in the last couple of years and one of the things that's changed that we might want to highlight is that Lisa Nelson has actually put

forward and balloted a personal advanced care plan through HL7.

So, there's now an implementation guide that creates a way to exchange a standardized electronic documented, a consolidated CDA document. And since that's going to be the coin of the realm for exchanging information in the healthcare system, looking at how this current measure might tie back to the components that Lisa Nelson has in the current document might be very helpful, because that's how it's going to get spread.

MEMBER SCHULTZ: Yes. I would like to just sort of emphasize that I think we've heard support for this right now, there's clearly a gap right now, but there is a part of me that feels like this is a check-the-box measure and I know we've had discussions over the years in this Committee about that's frustrating, but some of that is sort of where the field is at right now, but I really would encourage the Developers, like, start thinking ahead, right?

Get ahead of the curve, think about what this measure's going to look like in the next three years and three years after that, because it takes a lot of time to push things forward.

But I think this is a space where, particularly if this measure is successful in getting more people to spend time on advance care planning, then we want to think about, what's in the advance care plan? How's it being shared with other providers? How's it being shared with family? How is that connecting to the care that the individual actually receives? Is there an outpatient reported outcome measure that might be on the horizon?

We're not there yet, but how would it connect with actually having care that's concurrent with an individual's wishes? So, thinking ahead down the line, so that -- I don't want to be back here in five years debating the same check-the-box measures. And I will say that across the portfolio of what we're doing, I don't

want to pick just on you.

CO-CHAIR CASEY: So, Chris, I know you have your hand up, but let me just say, in the interest of time, a lot of what we're discussing now is moving into the aspirational phase of what we need to discuss when we get to the Gaps section. Certainly, ACP is actually an important part of the NQF preferred practices in care coordination as well.

So, I would like to move us along, if that's okay, Chris, and vote on this particular section, knowing that a lot of what you're saying will also carry over into the Gaps discussion. Make sense? Thank you. So, I guess, maybe, what would you -- we need a formal vote, so I would ask for a motion, please.

CO-CHAIR LAMB: Yetunde wants to give an opening.

CO-CHAIR CASEY: You want to vote? Okay, you're ready.

MS. OGUNGBEMI: I can't vote.

CO-CHAIR CASEY: Now I get it. I get

it --

MS. OGUNGBEMI: I want to --

CO-CHAIR CASEY: -- you want to give us information about the vote, okay.

MS. OGUNGBEMI: Yes, sir.

CO-CHAIR CASEY: I understand.

MS. OGUNGBEMI: Yes. All right. Does everyone in the room, Committee Members only, have a blue remote? If not, please let me know now so I can get you one, because we will be voting very shortly. Okay. So, for voting, you will use that blue remote and select one of four options. Yes.

So, it will be 1, 2, 3, or 4. On all the Criteria that we vote on, those will be your options. You will point your clicker or remote towards me, because I have the small device that captures the votes. You can vote as many times as you'd like, but the last vote that you press is the only one that will be captured. So, you cannot vote multiple times.

I will announce what we are voting on,

what measure, the title, what criteria, your options, and when voting is open. I will also announce when voting is closed and the results on whether the measure has passed, consensus is not reached, we're in a grey zone, or the measure did not pass.

My colleague, May, will vote proxy for Colby and Lorna, who are on the phone, and they will send their votes in via chat. So, are there any questions? Okay. So, we're going to do a test vote, just to make sure that you guys got all that information that I gave you.

So, the test vote is, what are the must-pass criteria included in measure evaluation? Your options are: 1, Importance to Measure and Report and Feasibility; 2, Feasibility and Usability; 3, Importance to Measure and Report and Scientific Acceptability; and 4, Scientific Acceptability and Usability. Voting is open.

Also, our quorum is 14 Members, and I believe that we have quorum, so we will wait

until we have everyone's vote. If the people on the phone would like to vote, please enter your chat.

MEMBER HOHL: Is there a written document of what you said the numbers 1 through 4 are?

MS. OGUNGBEMI: So, usually, it's easier, but I was trying to be clever this morning. So, when you vote, it will be: 1, High; 2, Moderate; 3, Low; and 4, Insufficient, but during the example, I made it a little tricky.

MEMBER HOHL: Oh, okay. Okay, got it.

MS. OGUNGBEMI: So, no. Okay. So, let's see. So, voting is closed. We have one vote for Importance to Measure and Report and Feasibility; two votes for Feasibility and, three votes, pardon me, for Feasibility and Usability; eight votes for Importance to Measure and Report and Scientific Acceptability; and one vote for Scientific Acceptability and Usability.

The answer is 3, Importance to Measure and Report and Scientific Acceptability. I can

also show you what percentages we have. So, we reached a consensus on 3, which is Importance to Measure and Report and Scientific Acceptability, so thank you all for paying attention to my presentation earlier.

We didn't reach quorum that time, because the people on the phone did not vote, but we will -- we have to this time. Yes. Okay. So, now we will vote for real. And we are voting on measure 0326 Advance Care Plan on Evidence. This is a must-pass --

MS. MUNTHALI: Excuse me, Yetunde, we're voting on Performance Gap.

MS. OGUNGBEMI: Oh, pardon me. Performance Gap, sorry. I got ahead of myself. Here we are. Thank you. So, we're now voting on Performance Gap for measure 0326. Your options are: 1, High; 2, Moderate; 3, Low; and 4, Insufficient. Voting is open.

Okay. Voting results are: four High, 12 Moderate, one Low, and zero Insufficient; 24 percent High, 71 percent Moderate, 6 percent Low,

and 0 percent Insufficient. Measure 0326 passes on Performance Gap.

CO-CHAIR LAMB: Okay. We're going to move on to Reliability now. Jeff, are you still on for first or is Shari? Okay, Shari.

MEMBER ERICKSON: This is my turn. Okay. So, let's see if I can --

CO-CHAIR CASEY: Shari, before you --

MEMBER ERICKSON: Yes?

CO-CHAIR CASEY: -- begin, I would suggest, with all due respect to the excellent work Jeff did, that you don't need to read through everything.

MEMBER ERICKSON: Okay.

CO-CHAIR CASEY: And you can sort of narrate through it --

MEMBER ERICKSON: Oh, okay.

CO-CHAIR CASEY: -- because we've read it and we've discussed it.

MEMBER ERICKSON: Okay.

CO-CHAIR CASEY: Obviously, if there are important things to highlight, you'd want to

do that, but --

MEMBER ERICKSON: Right, sure.

CO-CHAIR CASEY: -- I think we can do well.

MEMBER ERICKSON: Okay. So, I'm just doing Reliability first, right? Just Reliability?

CO-CHAIR CASEY: Right.

MEMBER ERICKSON: Okay. So, I won't go over, then, the numerator, denominators, and exclusion statements, because we covered those already. There was no new reliability testing that was provided, or no updated testing that was provided. As you saw in here, it was a data element level testing, included percent agreement and the kappa statistic. And the kappa statistic, kappa score, was 0.97.

And I believe it was because it was a data, if I'm remembering the algorithm correctly, because of the data element, even with a kappa statistic, it is a Moderate in terms of reliability testing, at least how that played out

from the guidance we received and the feedback that individuals provided.

Let me jump down to that and see if there are other things I want to summarize. Let's see here. In terms of comments from the Committee on the specifications, overall, I think all the comments found no inconsistencies, that the specifications were consistent with the evidence, and the testing appeared to be adequate overall. Let's see here.

One comment, though, was that reliability testing was based on a small sample of records from only four sites, which raises questions about generalizability across U.S. population, however the reliability testing that was performed showed strong reliability. And others basically said, adequate testing from 2009. One other person said it wasn't clear.

So, that's the summary of the comments, the pre-evaluation comments from the Committee, based on the reliability testing, which, again, was, as far as I could tell, was

not updated from the prior data from 2009. So, I'll stop there and see if Jeff or others want to add to comments on the reliability testing.

MEMBER WIEFERICH: I have none right now.

MEMBER ERICKSON: Lorna?

MS. STREETER: From Lorna, she said, I do not think there is a need to rediscuss or revote on Reliability.

MEMBER ERICKSON: Do we have to vote on Reliability, though?

MS. STREETER: Yes.

MEMBER ERICKSON: We do have to vote on it, okay. Only if needed? Oh, okay.

MS. MUNTHALI: So, there were changes to reliability testing, it sounds like. Mary, can you confirm?

MEMBER ERICKSON: Yes, I didn't see any updates.

MS. MUNTHALI: No changes? If there are no changes, then another motion on the table to accept the previous testing.

MEMBER ERICKSON: Can I move to accept the previous -- oh, sorry. Discussion.

MEMBER KOPLEFF: Sure. Just a question. I noticed in the specifications that there's an exclusion for, or it looks like an exclusion, for clinicians indicating the place of service is the emergency department. I know and understand there were ER docs on this expert panel and I can make my own assumptions about why this would be an appropriate exclusion.

I'm not necessarily disagreeing with it, but would like some input from either the Developer or our ER docs at the table regarding sort of the ability for the ER to be a useful place to measure or not measure this measure, as it contributes to the spectrum of coordination across settings.

CO-CHAIR CASEY: Please. Charissa, do you want to comment first? Go ahead.

MEMBER PACELLA: So, my thought would be, it would depend greatly on the reasons for the patient being in the emergency department.

So, I think that, to that extent, excluding is way more clean, potentially, than trying to tease out which patients really need it and which don't. So, I'm guessing that that's probably the impetus behind that exclusion.

CO-CHAIR CASEY: Yes, Shari? Ellen, do you want to speak? Okay, sorry. Go ahead.

MEMBER ERICKSON: Yes. I mean, I guess I would -- that would make sense to me. And getting at the earlier issue discussed, in terms of an ongoing source of care, having an advance care plan, something that was done in an emergency department is -- there's a face validity issue there, in terms of that meeting face validity in terms of this definition.

But in terms of being able to follow-on, follow up on that and meaningful care coordination that one would want to occur based on an advance care plan, I have a separate comment too, just because I feel like it needs to be made in this context, which is, again, with regard to these new CPT codes that I think need

to be incorporated with this for this to be a relevant measure moving forward.

CO-CHAIR CASEY: And I think it's a really good question and I do think it's good feedback for the Measure Developers, because I know there is, in parts of the country, some reasonable evidence around the involvement of the emergency department as an interface for advance care planning. But I think for the purposes of what Charissa has talked about, I think, it seems like this just helps us be more precise with the measure.

DR. SANDBERG: Thanks for that discussion.

MEMBER BECKWITH: I just have a question about that. Are we saying then that in the emergency department, we're not going to follow the advance directive? I mean, that's really why some of that conversation concerned me, because I know my -- yes, that really concerned me. So, just asking for clarification.

MEMBER PACELLA: So, I apologize if I

was not clear. But, no, I was speaking to the measure as written in terms of documentation of what the advance care plan is, which I think is quite different from whether or not you are aware of who -- the documentation piece, I think is quite different from the actual patient care piece, potentially in this case, especially in an emergency department.

MEMBER BECKWITH: But I would just speculate or observe that probably in the ER is the most important place to be sure that there is documentation about advanced directive and the advance planning, or even the healthcare surrogate. So --

MEMBER PACELLA: And, again, I --

MEMBER BECKWITH: -- excluding it --

MEMBER PACELLA: -- would say that probably depends a little bit on why the patient is there and the context. So, it would be hard to say that for every single patient whose of a certain age in an emergency department, I think. And I think that's probably, that kind of

messiness is probably why they would limit applicability to make that blanket statement for everybody.

MEMBER BECKWITH: I understand what you're saying. It just seems to me as though it's so important about what happens there, that this should not be excluded from the -- it would be the denominator, right?

CO-CHAIR CASEY: Okay, thank you.

MEMBER ANTONELLI: Just a clarification, I'm mindful of systems that aren't necessarily connected yet; it kind of builds on Terry's point about thinking about electronic connectivity. Could you speak a little bit about what meets the measure? So, where this plan is found, if it's in the hospital EMR, is it in the primary care or an ambulatory setting, is it any of the above meets the measure?

DR. SANDBERG: Yes. Thank you for that. Any of the settings meet the measure. It's an administrative, claims-based measure. So, they're looking for CPT II quality codes that

indicate that there is documentation or that patient -- it was raised, but the patient did not wish to discuss.

MEMBER ANTONELLI: So, may I have a follow-on to that? So, I think to the degree that the creation of a care plan is a process measure, but doesn't extend anywhere else across the care team, is a significant gap. And I don't intend this to be aspirational, but I'm just sort of thinking about the availability of that care plan being measured somewhere else.

So, if it's created in the inpatient setting, it would be great if the measure actually -- to meet the measure is in the primary care or the consulting ambulatory sub-specialist or the behavioral specialist, actually can access it as well.

So, I'm mindful that we've got history with this, I like it in spirit, but I'm going to argue that I think that this really undersells what we're trying to promote in terms of care coordination.

Stalin likes to use, and I quote him all the time, it's a bilateral handshake. I still see this is sort of the unilateral handshake, but directionally, it's where we need to start.

CO-CHAIR CASEY: It's Wellington's aspiration, right? And I think, Rich, what you're saying is, there should be one advance care plan, not advance care plans, right? That's really what you're talking about, is one plan. Which is in our preferred practices.

MEMBER ANTONELLI: It's creation in one locus. I would argue that, I'm going to drop a CPT code because I did it, I'm the hospitalist. But I actually think the PCP, it's his receipt of that care plan that really pushes this from care in one setting to care coordination across settings.

So, I'm sort of struggling with the measure, but I do recognize we're starting from a humble and important point. But I'd love it if the numerator was the care plan is available to

somebody that didn't create it.

CO-CHAIR CASEY: Any other discussion? This is great.

MEMBER ERICKSON: So, it sounds as if, given that there's not updated testing, that I would move that we do not need to vote on reliability testing for this measure. Any second? Do we need a second? Jeff, my --

CO-CHAIR CASEY: No more discussion?

CO-CHAIR LAMB: Validity?

CO-CHAIR CASEY: Chris, go ahead.

MEMBER DEZII: So, the numerator, patients who have an advance care plan documented in the medical record, which means one exists, right? That's what that means. And if it doesn't exist, then an advance care plan, we need to discuss with the patient and almost create one there or there wasn't able to name a decision-maker?

Those are two different things, right? They're two big things, I think. It goes to your point about trying to keep it clean, but I don't

know how to vote on this. Is anyone as --

CO-CHAIR CASEY: Chris, I think the question on the table is whether it's okay that we not vote on it and move on and accept it as is. Am I right? In terms of Reliability, that we've already determined this, so if you're speaking against not having a vote, that would be in order. Okay. But certainly, save those thoughts for our Gaps, okay? Because I think it's important. Thanks.

MEMBER ERICKSON: So, my understanding is that, because the prior -- when this was voted through previously for endorsement, the reliability testing then was voted with a consensus, there was a consensus around the reliability testing at that point. So, at this point, we would not be voting, because we would be accepting the vote of the previous Committee in 2009 that the reliability testing was --

CO-CHAIR CASEY: It's unchanged.

MEMBER ERICKSON: -- acceptable.

CO-CHAIR CASEY: Yes.

MEMBER ERICKSON: Okay.

CO-CHAIR CASEY: Good.

CO-CHAIR LAMB: And we have a second, so we're good. Validity?

CO-CHAIR CASEY: We're good.

MEMBER ERICKSON: I'm back on. So, validity testing -- whoops, I just lost my page. So, if I recall correctly -- then I find it, there -- it was a measure score validity level testing with face validity. And it was an expert panel, they were looking at inter-rater reliability, and it came out at an average rating of 4.35 on a five point scale.

I think this was not new, updated testing, right? This was previous testing data that was presented that was voted through with consensus from the prior Committee, same essentially as the reliability testing. So, in many ways, we're in sort of the same place, the data at that point was viewed as acceptable and voted through.

And so, this Committee, we can discuss

if we feel like that's sufficient or if we need to call for the Measure Developer to do further reliability testing or vote on whether or not this is -- to see if there's consensus again around this. So, is there anything else we should summarize with regard to that?

CO-CHAIR LAMB: Jeff, anything to add?

MEMBER WIEFERICH: Nothing right now.

CO-CHAIR LAMB: Do we have anything from Lorna?

MEMBER ERICKSON: Can I ask a question? In terms of, does this discussion, is it also inclusive of the threats piece or are we sticking to the testing at this point on Validity?

CO-CHAIR LAMB: Threats are part of it.

MEMBER ERICKSON: Threats are part, okay. So, let me just take a moment to say something about that. I think that there was view that there, at least from the original review, that there's some room for improvement in terms of the validity testing. Let me just get down to those notes, excuse me one moment.

So, validity testing, again, in terms of the Committee, I just wanted to, I didn't do this before, the approach to Validity seems sound overall, but the comments from the Committee, there was a note from one Committee Member that it would have been good to see empirical validity testing for future consideration.

In terms of the threats to Validity, it was noted that exclusions are not applicable, which, let's see here, seems appropriate, because the measure numerator is focused on having the discussion with the patient, even if the patient decides not to name a surrogate decision-maker or an advance care plan. Let's see here.

The -- a note from another Committee Member was, the observed variation across practices suggests that the measure detects meaningful differences in quality. And somebody else noted that, while they don't see it as a threat to Validity, but specifications indicate clinicians indicating the place of service is the ED, which we were talking about before, are

excluded.

So, we had that discussion already, if we want to reopen that with regard to Validity, we could do so. This person did note they would be interested in hearing from the Developer on the rationale and approach to this exclusion. Again, we did discuss that somewhat already. So, I think now I'm done. Just wanted to be sure I got it all in there.

CO-CHAIR LAMB: Does Lorna have anything?

MS. STREETER: Nothing to add.

CO-CHAIR CASEY: I just have a question for NCQA. Have you gotten any indication from CMS about when or if you might hear back around the use of the new CPT codes? Have they indicated to you?

DR. SANDBERG: No, we're approaching that with them, but --

CO-CHAIR CASEY: The only concern I have is that, given that this is being promulgated now through the Quality Payment

Program with the CPT that does provide additional reimbursement, which has been one of the major barriers, there may be, in the interim, some face validity problems because of that.

And so, I don't know how you reconcile that in the context of the CDP, but it seems like you would want to get on that pretty quick to be sure that -- because this would help you, right, promote the measure?

DR. SANDBERG: Right. Historically, they've been reluctant to include billing codes in the specifications for the lobbying --

CO-CHAIR CASEY: True, but it may have some sort of impact on the measure that we hope would be positive, right?

DR. BARTON: You can be sure that we will pursue this vigorously. It has not been our experience that, in any case, CMS has been quick to respond to our questions or that CMS -- that we have been the slow partner in those kind of discussions, but we will do our very best.

CO-CHAIR CASEY: Well, we're hoping

that Dr. Agrawal will help figure that out, right?

(Laughter.)

CO-CHAIR LAMB: A question for the Measure Developers. It strikes me, in looking at the measures that are Maintenance Measures, that we typically have content and face validity. This is in PQRS, you've said that it should be in MIPS, is there an opportunity going forward to look at other types of validity so that we can move beyond content and face into -- that connect to the outcomes?

I mean, is that ever a part of this? Because typically when we see Maintenance, face and content are not updated. It's just a question of, now that it's in PQRS and there's more data, do you think that that would be something that would possible to come back to us?

DR. BARTON: I think that's a great suggestion. As PQRS is, of course, changing in front of our eyes and whether -- if CMS is willing to share data that's relevant to the

reporting units and if, ideally, at some point, there's a real effort to include all the patients and not just the ones that the providers want to report on, I think we would be very eager to leverage that kind of data to try and continue testing.

CO-CHAIR CASEY: I think Dr. Price said he was a Medicare beneficiary in his testimony, so you might want to do some face validity with him.

(Laughter.)

CO-CHAIR LAMB: Other comments about Validity? We're still on Validity. Okay, Shari, do you want to make a recommendation?

MEMBER ERICKSON: Well, I have one more comment/question. And just getting at what Don was raising, I think those CPT codes have to be in here. I mean, thinking about what I'm doing at ACP and trying to get our members to use these codes, I mean, these are valuable to them.

This is stuff we've advocated for years to have paid for, along with other codes

that we've been trying to get on the books. Us, AAFP, AOA, all of the primary care societies are pushing hard for our members to use these new codes.

And then, if they don't -- and then, they may not even realize the specs don't include them, so they go through the list of measures on the QPP site and they say, oh, I'm doing that, boom, and then they don't get counted for it, they don't get credit. They're going to get mad and I'm going to hear about it.

And so, anyway, this is the stuff that really matters to the physicians on the ground and it's stuff that they will not realize. And so, I think it has to be moved and I understand you're in a rate limiting step here, but, I mean, I guess I would be curious -- and maybe this is partially a question, in terms of what is involved in getting that in there?

Because I'm not a Measure Developer, I mean, I understand the construct of measures and I understand how they apply to our members on

the ground, but as the Developer, how hard is it to get those into the measure specs?

CO-CHAIR CASEY: Shari, can I --

MEMBER ERICKSON: Yes.

CO-CHAIR CASEY: -- because I think this is good feedback --

MEMBER ERICKSON: Sorry.

CO-CHAIR CASEY: -- but Elisa may actually have a technical --

MEMBER ERICKSON: Oh, sorry.

CO-CHAIR CASEY: -- assistance here to help us --

MEMBER ERICKSON: Okay.

CO-CHAIR CASEY: -- through both sides of this.

MEMBER ERICKSON: Okay.

CO-CHAIR CASEY: Because I think everyone's in agreement with you.

MEMBER ERICKSON: Okay.

MS. MUNTHALI: Yes. So, Don did ask whether or not we still have time limited endorsement and this is where we would ask the

Developer to come back after a year. We do not have that for measures that are not eCQMs.

We do have it somewhat for eCQMs, Electronic Clinical Quality Measures, where there hasn't been testing and we do allow up to three years for a measure to go out in the field, come back with sufficient testing.

It does sound like you do want this measure to continue its endorsement, but you have some concerns about the inclusion of the CPT codes in the specifications. What we can do in the report is write a strong recommendation for NCQA at the next maintenance review in three years, that they come back with that specification.

It sounds like they're having some dialogue with CMS, not as quickly as they would like those discussions to have advanced. But right now, that would be the most we could do. You're accepting the validity testing from the last maintenance review.

And, unfortunately, there is no way to

force NCQA to do it, they are making an effort to do it, but we can write that strong recommendation in the report. And the other option, too, would be for you to vote on it, if you wanted to vote on this Subcriteria.

We did say before, if you had accepted the consensus agreement from the last review, you could do that, but if you're still apprehensive about the results from the last review -- knowing what you know now -- after this measure has been implemented, you can also vote on it.

CO-CHAIR CASEY: Terry?

MEMBER O'MALLEY: This is to extend Shari's comment. And it's really about specifications of what does it mean, what do you have to have in place to get credit, A, for the CPT code, but, B, for this measure, and shouldn't they be aligned? And it's really part of just a general process of aligning standards and aligning expectations across multiple domains, I guess.

So, I guess, for the Measure

Developers, this is either a chance to put down a marker that says, this is what the standard is for including, these are the components of an advance care plan, we expect to see these for you to get credit.

Now, whether or not that's what CMS says, it would be nice if it were, but somewhere, someone's got to sort of put the line in the sand and say, this is the minimum criteria that's needed, and move us forward there.

MEMBER GAGE: I'd like to ask, are we allowed to propose that something be passed with a modification? As someone that has experience in developing measures, I would think that CMS would -- I mean, you don't need to ask permission to respecify your specification for information that's already available in the claim.

DR. BARTON: I think, between now and August, we're working on all of these measures with CMS that are in the QPP. I think that specifically here, we would have to request a G code to cover the CPT codes that we want to

allow. So, that's an administrative step that we plan to take.

MEMBER GAGE: Got it. So, as a process question, are we allowed to pass a measure with a recommendation that it be updated to keep pace with the rules of the Medicare Program?

MS. MUNTHALI: So, what you could do is, given this timeline that Mary just spoke of, Mary, could you come back at annual update with an update to the Committee?

DR. BARTON: That's probably the best time to bring the updated specification --

MS. MUNTHALI: Yes.

DR. BARTON: -- I would agree.

MS. MUNTHALI: So, we do have an annual update process, not outside of process, part of our current process, in which NCQA could come back. We write that in the report and we'll follow up with NCQA to make sure they have that information to you at the annual update.

CO-CHAIR LAMB: Elisa, can you just clarify, in terms of the vote, if that gets

written into the recommendations, that should not influence the vote, that's just assumed that --

MS. MUNTHALI: Correct.

CO-CHAIR LAMB: -- that would go forward?

MS. MUNTHALI: Correct. So, it's not a conditional recommendation, but it is something that you've asked NCQA to follow-up with.

CO-CHAIR CASEY: Rich?

MEMBER ANTONELLI: What did you say the time frame would be for that?

MS. MUNTHALI: The annual update process kicks in from the endorsement date, so a year from that. And so, we could probably discuss this over a webinar within a year.

CO-CHAIR LAMB: If this is sidetracking, I'll rely on you and others. Terry, your comment about alignment between the CPT and the measure, does that go both ways? Because CMS has made a decision about what the CPT is going to be, what if the measure is a more precise or valid measure than what CMS is

requesting? Is it a two-way street in terms of changing CMS CPTs?

MEMBER O'MALLEY: Yes, speaking for CMS, I would like to say --

(Laughter.)

MEMBER O'MALLEY: I think that CMS has already indicated what it considers the requirements for making a valid claim under this code. I think that's the minimum standard, so I would think the next step is to say, this is what CMS really should have done, and have it include the CMS measure, but make it even more precise and more extensive, so that if you meet the new measure, it will cover CMS.

I mean, that's sort of the ideal thing. So, kick the can down the, no, move the ball, not kick the can, move the ball down the road. But have it so that you're not putting a measure that's in conflict with CMS, you're using the CMS measure to actually move yours forward.

CO-CHAIR CASEY: Don't forget, this has to go through a couple of other higher level

discussions before we get to heaven, so to speak, but I think we got the message out and we've figured out a pathway. So, yes, Shari? Sure.

MEMBER ERICKSON: And maybe this is a Usability piece, I can throw them out there and if we decide that they need to be weighted on, they're directly following this. And one is, any plans around e-specification for this measure? That would be helpful to know, because that gets at what you were raising earlier.

And then, the second one is, you were mentioning the establishment of a G code for the purposes of the CPT codes that -- the new CPT codes. Logistically, I guess, in terms of the physician on the ground who is reporting on the measure, again, maybe this is a Usability question, but the -- so, they would need to be documenting both the CPT code and the G code to be able to get credit for the measure? Is that accurate?

CO-CHAIR CASEY: Can we hold that until Usability?

MEMBER ERICKSON: Okay. We can --

CO-CHAIR CASEY: I think it is --

MEMBER ERICKSON: -- hold it to Usability.

CO-CHAIR CASEY: -- yes, let's --

MEMBER ERICKSON: That's fine. I just -- yes, okay.

CO-CHAIR CASEY: Yes. But I think it's valid and so, why don't we -- any other points? So, Shari, do you want to -- know that we've done a parenthetical --

MEMBER ERICKSON: Hey, we've done a lot of --

CO-CHAIR CASEY: -- on this.

MEMBER ERICKSON: So, I guess the question is whether or not we feel, given this discussion, there is a vote needed on the Validity and the threats to Validity for this measure, or do we accept the Validity data that was presented previously? And I have to admit, I'm torn, so I guess I could move one way or the other and then we can vote. How do you process

wise want to handle that?

CO-CHAIR CASEY: Make a decision.

(Laughter.)

MEMBER ERICKSON: So, I would move that we would vote on the Validity, given the significance of the discussion and the comments that have been put out there, that we as a Committee revote, even in the face of not having updated validity data, on the validity of the measure.

CO-CHAIR CASEY: With the -- any second? Jeff seconds. Any discussion? And I think this will be delivered with, as I said, a big parenthetical that NCQA has been very collegial about.

MEMBER ERICKSON: Yes, absolutely. Yes.

MS. MUNTHALI: And we just wanted to remind you that the highest possible rating, based on the NQF algorithm for Validity, is Moderate. So, the rating scale has changed. So, it's: 1, Moderate; 2, Low; 3, Insufficient.

CO-CHAIR LAMB: Can we just have some clarification before we move on that in terms of the implications? Because I think we've talked a lot about the limitations of where we are right now, but if we vote Low to make the point that we want that next thing, what is that going to do to this measure?

MS. MUNTHALI: That would fail the measure.

CO-CHAIR LAMB: I think we need to understand that, that there's two things going on here, which is, we want to see this come back, but if we make the point through voting Low, the measure will not go forward as a Maintenance Measure. I think we just need to be very clear on that. Everybody clear? Okay. Do we want to have discussion, then, in terms of a vote? Barbara?

MEMBER GAGE: I'm getting a little nervous that we're setting a standard that's above the current empirical evidence, which would be setting a standard -- it would be setting a

bar that the Developers could not hit at this point in time. Which seems inconsistent with our earlier discussion about the importance of having this measure as a baseline beginning of measurement in this area.

So, am I allowed to -- so, my opinion would be to go with the Validity vote that was already underway until next time, when we have actual data from the use of the codes and can revisit.

CO-CHAIR CASEY: Thank you. The motion is to proceed with a vote or not, correct?

CO-CHAIR LAMB: Just in terms of Robert's Rules here, which I don't know --

(Laughter.)

CO-CHAIR LAMB: -- is we now have a recommendation to vote, with a second, and we now have a counter-recommendation not to vote, and I'll second that. What do we do now, Yetunde?

MS. MUNTHALI: So, perhaps a hand vote? Who thinks we should vote on Validity and not accept the previous voting on Validity?

MEMBER COLLER: Can I --

MS. OGUNGBEMI: Well, voting -- oh, sorry.

MEMBER COLLER: Can I ask a quick question that would, I think, affect my vote? And I can invoke being a new Member and ignorance for the question. The standard that we're supposed to set for voting on Validity for this measure is the same as if it was a new measure or a Maintenance Measure, correct? I just wanted to --

CO-CHAIR CASEY: That's correct, yes.

MEMBER COLLER: -- make sure I understood that appropriately.

MS. MUNTHALI: Yes. And the reason why, and I should have explained it, it is Moderate and it's the highest, is because they did not submit empirical testing, it is only face validity. And even if it was a new measure that came in, the highest with face validity would be a Moderate.

CO-CHAIR CASEY: So, I'm -- I will hold

myself out as a very amateur Parliamentarian and say, the second motion was the obverse of the first motion, so I think the motion on the table is, do we want to proceed with a separate vote or not, correct? Yes. A new vote, right? So, that's the question on the table, does this Committee want to proceed with a new vote? Terry?

MEMBER O'MALLEY: Just a clarification. So, we're voting on the measure that says we should open up Validity for another vote. And so, if we vote yes to that, we are opening up a new discussion and a new vote. If we vote no and we defeat that measure, then the current Moderate standing that this measure has persists and remains and we do not vote again.

CO-CHAIR CASEY: That's correct. In other words, the vote is yes for a new vote --

MEMBER O'MALLEY: Yes.

CO-CHAIR CASEY: -- to refresh the old vote as opposed to leaving the old vote in place.

MEMBER O'MALLEY: Right.

CO-CHAIR CASEY: That's correct.

MEMBER O'MALLEY: So, if you vote no on the current measure --

CO-CHAIR CASEY: Right.

MEMBER O'MALLEY: -- then it will not change --

CO-CHAIR CASEY: That's right.

MEMBER O'MALLEY: -- the current score of the measure.

CO-CHAIR CASEY: Well, it won't -- it will not require us to vote again, that's what it will not require us to do. All right. Everyone is clear as possible? Let's do a show of hands, who is in favor of having a second vote, a new vote, raise your hand? Who is opposed to a new vote? Okay. So, it looks like -- and Shari's abstaining. Any other abstainers? Did we get a count there, Yetunde?

MS. OGUNGBEMI: It was very quick, but I thought 12.

CO-CHAIR CASEY: It looked like the majority in the room, but I don't know -- it

looks like it passed the majority without our people on the line. So, we will not vote again, we will accept the previous vote on Validity and move ahead. So, we're past our time here from 10:30, so we want to move this on.

CO-CHAIR LAMB: Feasibility?

MEMBER ERICKSON: All right. So, Feasibility. Okay. So, Feasibility, the report was that all data elements are electronically defined fields, as we've discussed. They are -- claims data is used pretty much exclusively for this purpose.

The comments were that, it appears the data elements are able to be generated. The issue is whether or not, given the evolution of EHRs, if there's some other ways to do post-market surveillance to be sure that the data elements are generated in the course of care delivery.

I think that's probably true, given that it's codes, although that brings up the question again related to the new codes and their

impact on that. The measure relies on claims data and ultimately, one individual, with the continued use of the PQRS Program, supports Feasibility and Usability.

Let's see, I think those were the major concerns that were raised or the thoughts that were provided by the Committee, as summarized in our report. I don't know if, Jeff, you want to add anything more to that?

MEMBER WIEFERICH: No, I'm good.

MEMBER ERICKSON: Lorna?

MS. STREETER: Nothing to add.

CO-CHAIR LAMB: Any discussion?

CO-CHAIR CASEY: Shari?

MEMBER ERICKSON: I actually have a question for Terry. Given your experience, I mean, do you have any thoughts or concerns related to the ability for the data for this measure to be collected?

MEMBER O'MALLEY: There are probably a couple of steps yet to be done, so you really need to have very clear specifications on what

the data elements are. And then, you need to link them to a code. So, it's either a LOINC or a SNOMED code. I think those already exist, but I don't know if anyone's lined them up.

MEMBER ANTONELLI: I was actually going to ask Terry that same question.

(Laughter.)

MEMBER ANTONELLI: I think that, and in fact, I may push you or others to think a little bit more deeply, I think this is an opportunity to see about getting this alignment where we want to go, right? So, I'm still going to say, it's a low-water mark that an ACP exists somewhere.

To the degree that, what are the elements in the EMR that actually say, this is what an ACP is, so however we might want to frame those in our comments is important, but I think in fact this could push the EMR community, the EHR developers, in the right direction. So, if we could gather a little bit more input, and whether you want to riff on it some more, Terry, or others, but I just can't let this piece go and

give it an easy pass.

CO-CHAIR LAMB: Question to Elisa on that, we will see the recommendations that go along with all these, so that in our future calls, we can keep it on the table and we will have a chance to talk about in Measure Gaps the things that are priorities and, certainly, this has received enough emphasis that I think we can say that that alignment is a key discussion point and a recommendation from this group.

MEMBER ANTONELLI: And if I could call this out, so, I know when we're building systems or building contracts for performance, having a criteria around feasibility that's high, a high likelihood of feasibility, everybody immediately jumps to, well, claims data is really good. And I think we recognize that there's limitations with that.

So, I want to make sure that the group understands that just because it's highly feasible doesn't necessarily mean it's highly valuable for what Care Coordination Measure folks

are thinking about. So, that's sort of the framing that I'd like to bring forward.

CO-CHAIR LAMB: May I ask, Elisa, also, is Reliability, Validity are must-pass at the Moderate level, what about Feasibility? Can we make a point on Feasibility and not harm the measure going forward?

MS. MUNTHALI: Yes. Feasibility and Usability and Use are not must-pass, so if they did fail, the measure could still move forward.

MEMBER O'MALLEY: Just to follow-up on Rich's point, claims data are notoriously difficult to interpret correctly. And it should be possible to query the EHR with the proper codes and create a care plan independent of claims data.

I mean, that should not be a leap, that should be easily done when the specifications are very clear. And there's going to be some development work and the EHR vendors will have to do it.

But all the EHR vendors, the certified

EHR vendors, have to be able to consume, create, and exchange a consolidated CDA document. Period, the end. So, they're already there, they just need to have the specifications be really good.

CO-CHAIR CASEY: I would say that the triple pathway of, this measure, should it be maintained, continuing with the Quality Payment Program? The promotion of the use of the CPT codes and the speed at which CMS wants to move to e-Quality Measures are going to help us a lot. So, I don't worry about this. Shari?

MEMBER ERICKSON: I just have a question about Feasibility versus Usability and Use. I mean, to mean -- this is blending a little bit and I guess I want to be clear when we've voting what we really mean by the Feasibility piece versus Usability and Use.

Because some of it seems to me that you could argue the feasibility of the data collection versus usability or use of a clinician on the ground to be able to get the data in the

right places. I mean, is that -- I'm trying to figure out really where we draw that line, so I know which one -- what I'm --

DR. TERRY: So, Feasibility is your ability actually to be able to get the data --

MEMBER ERICKSON: Out?

DR. TERRY: -- easily. Right.

MEMBER ERICKSON: Or reported in?

DR. TERRY: Exactly.

MEMBER ERICKSON: Or both?

DR. TERRY: Out.

MEMBER ERICKSON: Okay.

DR. TERRY: What you -- how you have to get it, whether it's in the health record or whatever --

MEMBER ERICKSON: Okay.

DR. TERRY: -- claims. Usability, is it in use somewhere --

MEMBER ERICKSON: Okay.

DR. TERRY: -- in what programs? So, is it currently in use in a federal program or others? So, that's what Usability --

MEMBER ERICKSON: Okay. And --

DR. TERRY: -- speaks to.

MEMBER ERICKSON: -- is it useful? I mean, I guess that's the other part of -- do you get meaningful -- does it help you to improve care? Is that part of -- that's part of the Usability --

DR. TERRY: Yes.

MEMBER ERICKSON: -- piece, so not just using it, but it's useful? Okay. Thank you.

CO-CHAIR LAMB: Okay. Feasibility, if there are no more comments, we must vote on. Okay. And as Elisa and Peg have shared, this is not a must-pass. And so, I think we're ready to vote.

MS. OGUNGBEMI: Yes. We are now voting on measure 0326 for Feasibility. Your options are: 1, High; 2, Moderate; 3, Low; and 4, Insufficient. And voting is open. So, we have an n of 16 now, just in case you noticed. One of our remote participants had to step away for a brief moment.

So, our options are -- our results are: one vote High, 13 votes Moderate, two votes Low, and four votes Insufficient. And the percentages are: six percent High, 81 percent Moderate, 13 percent Low, and zero percent Insufficient. So, measure 0326 passes on Feasibility.

CO-CHAIR LAMB: Last Criteria for review on this measure is Usability. We will do harmonization and competing measures either at the end today or we'll do that in a separate call. So, this is the last one for this review. Usability, Shari, is that you?

MEMBER ERICKSON: I think I'm closing it out. Okay. So, Usability. So, as we talked about already, this measure is in use within the PQRS Program and is included in the Quality Payment Program MIPS Measures.

And so, it is being used, it's being used for reporting purposes and accountability purposes under that Program. Let's see here. Yes, I mean, I think those are the main pieces of

it.

I guess the issue, getting at, again, the issue of whether or not having the missing codes as part of it is an issue with regards to its usefulness, in terms of improving care. So, for the physicians on the ground, in particular, if they're reporting those codes, but aren't getting credit for it, so to speak, and then, they may not be finding it very useful.

CO-CHAIR CASEY: As an ACP member, I just want to remind you, it's qualified professional, right?

MEMBER ERICKSON: No, it's clinician.

CO-CHAIR CASEY: Clinician?

MEMBER ERICKSON: Yes. Well, qualified clinician --

CO-CHAIR CASEY: Qualified clinician, right.

MEMBER ERICKSON: -- is for the purpose of the --

CO-CHAIR CASEY: Right. Thank you.

MEMBER ERICKSON: Yes.

CO-CHAIR CASEY: Jeff?

MEMBER WIEFERICH: She covered it.

MS. STREETER: No comments from Lorna.

CO-CHAIR LAMB: Any comments? Barbara?

MEMBER GAGE: This is more a question. There's a note about the MAP having noted a couple years ago that for this measure to be used in the ASCs that it would need to be modified.

And in thinking about the movement towards standardized approaches, and it may not be relevant for this discussion, but how would it need to be modified and does that affect the Usability of the measure? The measure is being proposed for the physician community at this point, right? Or is it targeting a community?

DR. SANDBERG: I'm sorry, I didn't understand the question.

MEMBER GAGE: Sorry. There's a lot of work underway, and what I heard at the beginning was to be thinking in broader terms about how these measures fit into the larger environment of Measure Development.

And one of the comments that was in the materials was that the MAP had pointed out in 2015 that the measure would need to be modified to be applicable to the ambulatory surgery centers. And so, I was just asking how much that should affect our discussion of Usability?

Is this measure that we're looking at today being recommended for use with physicians, or is it being recommended for plans? No, it's the proportion, right? Right. So, does it matter that the Usability with the ASCs has been identified as limited, when we're thinking about the Usability of the measure?

DR. SANDBERG: I don't think it does.

DR. BURSTIN: The answer is, no.

MEMBER ANTONELLI: Just to -- this is probably a naive question, but I'd like to know the answer. The difference between current use in an accountability program and planned use, does that mean that the Measure Developer is aware that ACOs, for example, may or may not be -- is unaware that ACOs would be using this?

Because I'd be hard-pressed to imagine an ACO not keeping track of its end-of-life population. So, am I misreading what those categories are?

DR. BARTON: We don't have any special information about things going on in the delivery system and where the measures are going to be used. We know that CMS currently is using this measure in the precursor of the QPP and that's where we're continuing to work on refining the specification.

CO-CHAIR CASEY: Rich, you mean the Medicare Shared Savings Program. This is not a measure in the current structure of measures for MSSPs, but as you know, the vast majority of physicians are not, at least today, participating in the QPP --

MEMBER ANTONELLI: Yes.

CO-CHAIR CASEY: -- via that, it's through MIPS. So --

MEMBER ANTONELLI: Okay.

CO-CHAIR CASEY: -- most physicians could choose this measure.

MEMBER ANTONELLI: Okay. So, then, this is a very limited descriptor then. When it says no planned use in accountability program, it's very specific. This could be used in accountable arrangements, but the scan for this process doesn't necessarily pick up its use?

DR. SANDBERG: I think it means that we're, yes, we're not --

MEMBER ANTONELLI: Yes.

DR. SANDBERG: -- aware of its planned use, but it's not a definitive statement saying it will not --

MEMBER ANTONELLI: Got it.

DR. SANDBERG: -- be planned to be used.

MEMBER ANTONELLI: Got it. Okay. Thank you.

MEMBER ERICKSON: Related to that, so, within the Quality Payment Program, all of the Advanced Payment Models, Advanced Alternative Payment Models are required to use measures. To be defined as an Advanced Alternative Payment

Model, you have to use measures that are aligned with the MIPS Program.

So, yes, any of those Advanced Payment Models, Advanced Alternative Payment Models, could be choosing this measure, because it is part of the MIPS Program, even if they're in that other pathway.

MEMBER DEZII: I deferred my comments when you told me to defer them, and I assume this is the time. Getting back to Ellen's comment about her fear of check-the-box, I struggled with just about all the measures we looked at, but I really, in my own head, I just saw these measures -- as imperfect as they are -- as bridge measures to somewhere we want to get to.

I'd like to see -- we don't want a bridge to nowhere, okay, and I don't have -- your five years is very generous, I would really like to see some bridge in three years. Is there a way, when we approve these measures -- and I'm stealing the thunder I was going to give in my lead discussant thing, but what the hell --

could the Measure Developer advise, suggest, recommend future Measure Development, perhaps relevant to the outcomes and consequences of this measure going forward, and/or can you consider doing that yourself?

Like, you do primary Measure development, right? I mean, you're not just in measure maintenance? Which I'm not sure if the DCDR is in primary measure development, we'll see. Is that a reasonable -- do you folks understand me here? Okay. Response?

DR. BARTON: So, we are Measure Developers and we are currently developing a number of measures related to care coordination, under contract with CMS for Medicare Advantage Plans.

And of course, Medicare Advantage Plans have the advantage over the MIPS Program that they know who their denominator is, and so, you can apply a measure to the whole relevant population.

And so, in that case, we're working

exactly on the lines that Rich mentioned before, which is, we would like to see evidence that there's a care plan that follows a patient from one setting to another and that different clinicians all have access to.

So, we are absolutely working on those kind of measures. They would first appear, should they be successful in our development, in health plan use and then, presumably, maybe some day in ACO or Clinically Integrated Networks sort of use.

And that might be the best place to move the -- to say that we're rolling, we're moving towards. It's hard for me to imagine a golden future for individual clinician, one at a time measurement, in all honesty.

CO-CHAIR CASEY: I would like to say that is important feedback, but I'd like to keep us on the current, now Usability, question, because we have to vote on this. Shari?

MEMBER ERICKSON: Sorry, this is important to internists. The question I have is

related to other NCQA programs and its use there. So, I understand the patient-centered medical home program has evolved and is released now sort of in a new format that does have some credit given, so to speak, for some of the measures that physicians are, and I'm not going to get this right, but that are reporting on, that they get some credit, so to speak, in that program, to be recognized as a medical home for the use of certain measures and the reporting on certain measures.

I can't remember the details of that, but I know I've heard about that. So, I wasn't sure if this was one of those pieces that -- okay, it's not? Because it's not an eMeasure or e-spec measure? Right? Okay.

I was just curious about that, sort of whether it was being used there, because I think that's another connection into the Quality Payment Program on the clinician practice improvement, just improvement activities now, because that gives a lot of credit on that side.

And it -- I guess the other question related to that, is there any relevance, do you know, to, in the list of improvement activities, to advance care plan being on that list? Because that would be another just use. So, if you're reporting on this measure and you get credit over here too, I don't know if you know that and I can look it up --

DR. BARTON: I don't know that off the top of my head.

MEMBER ERICKSON: Okay.

CO-CHAIR CASEY: Shari, you're asking about the --

DR. BARTON: That's a great question.

CO-CHAIR CASEY: -- NCQA certification criteria?

MEMBER ERICKSON: Well, I'm asking two things, sorry.

CO-CHAIR CASEY: Okay.

MEMBER ERICKSON: Yes, I'm asking about NCQA certification criteria, which are relevant to the improvement activities piece on the MIPS

side. They're also relevant for the purposes of Advanced Alternative Payment Models, to an extent.

But also, then, direct relevance to the improvement activities, in terms of clinicians that are doing advanced care plans, if they can also check-the-box, for lack of a better way to put it, on improvement activities side --

CO-CHAIR CASEY: For QPP?

MEMBER ERICKSON: -- of the Quality --

CO-CHAIR CASEY: Yes, right.

MEMBER ERICKSON: -- Payment Program, of the MIPS component --

CO-CHAIR CASEY: Yes.

MEMBER ERICKSON: -- in the Quality Payment Program.

CO-CHAIR CASEY: I think that's more open-ended --

MEMBER ERICKSON: Right.

CO-CHAIR CASEY: -- at this point.

MEMBER ERICKSON: Yes. It would just be interesting, because then you get kind of, you

get credit, which is ideally, you want things to be connected across the program.

CO-CHAIR CASEY: Barbara?

MEMBER GAGE: So, along that same line that Shari just raised, the physicians that work in the nursing homes often point out that the measures that they're held to are not relevant for their populations. So, it would also probably be worth collaborating with the nursing home measure community too.

CO-CHAIR LAMB: I think these discussions are important. I would like to pull us back to CDP and make sure that we get through that today. Let's keep this on Gap discussion and recognizing it's a priority, but we're never going to get through CDP if we keep kind of going off on other important, but not CDP specific. So, can we vote on Usability?

MS. OGUNGBEMI: Yes. We are now voting on the Usability and Use for measure 0326. Your options are: 1, High; 2, Moderate; 3, Low; 4, Insufficient. Voting is open. Okay. So, as you

notice, one of our Committee Members also walked out of the room, but we still have quorum at 14 votes or above 14 votes.

Our results for Usability and Use for Measure 0326 are: one vote High, 14 votes Moderate, zero votes for Low and Insufficient. Percentages are: 7 percent High and 93 percent Moderate. So, Measure 0326 passes on Usability and Use.

CO-CHAIR LAMB: Okay. And I think that is the final review, so this measure passes to -- is that not true? You're shaking your head.

MS. OGUNGBEMI: We have to do Overall Suitability for Endorsement.

CO-CHAIR LAMB: Okay. All right. So, we have one more vote right now?

MS. OGUNGBEMI: One more.

CO-CHAIR LAMB: All right.

MS. OGUNGBEMI: Just one more.

CO-CHAIR LAMB: Let's do it and then we'll take a break. All right. So, Suitability?

MS. OGUNGBEMI: Yes. We are now voting

on Measure 0326's Overall Suitability for Endorsement. Your options are: 1, yes; 2, no.

CO-CHAIR CASEY: And, Yetunde, this is a recommendation to the NQF Board, right?

MS. OGUNGBEMI: Yes.

CO-CHAIR CASEY: For --

MS. MUNTHALI: The CSAC.

MS. OGUNGBEMI: Well, the CSAC.

CO-CHAIR CASEY: For the CSAC.

MS. OGUNGBEMI: Results are unanimous -- 15 votes yes, zero votes no, 100 percent yes votes. So, Measures 0326 is Overall Suitability for Endorsement is recommended.

CO-CHAIR LAMB: All right. Well, congratulations to us, we got through our first review. Thanks to the Measure Developers, very thoughtful, and thank you for hearing our comments. I'm going to shorten the break, if we can, to ten minutes, and see if we can kind of get some time back and move forward.

(Whereupon, the above-entitled matter went off the record at 10:56 a.m. and resumed at

11:13 a.m.)

CO-CHAIR CASEY: Okay. We're back in order. And I believe we have a quorum at the table. And if our Committee members on the phone are here, I think our next discussion will be around 3170 and 3171. And, Peg and Kate, are we going to hear first from --

MS. STREETER: Yes, he's on the phone.

CO-CHAIR CASEY: -- Dr. Kleinman? Dr. Kleinman, are you on the phone?

DR. KLEINMAN: I am. Can you hear me?

CO-CHAIR CASEY: Yes, Dr. Kleinman. We would appreciate it if you could capsulize your thoughts within a five-minute time frame, because we are time-constrained.

DR. KLEINMAN: I will do my best to do that. The staff had invited me to try to respond to your questions, but I'll try to do that as quickly as possible and hopefully --

CO-CHAIR CASEY: Thank you.

DR. KLEINMAN: -- within shorter than five minutes. First of all, thank you for the

opportunity to share this work with you, and I apologize I couldn't be there. I had hoped to be. My wife had a C-section a little under two weeks ago, so I am here in Cleveland. But --

CO-CHAIR CASEY: Congratulations.

DR. KLEINMAN: Thank you very much. She's very pretty, but I'll spare you all pictures.

(Laughter.)

DR. KLEINMAN: So the work that we're presenting comes from one of the AHRQ CMS CHIPRA Centers of Excellence, the Collaboration for Advancing Pediatric Quality Measures, that was initially funded at Mount Sinai and has now moved with me to Case Western Reserve University and University Hospitals, Rainbow Babies and Children's.

So, this work came from a formal peer-reviewed process that included scoping literature reviews, national expert panels, and a high level of stakeholder involvement. We were trying to push the envelope. I think we were envisioning

what I've heard this morning termed as bridging measures, things that really move the field forward, that are well-grounded, but also advance us.

So I hope that this, both these next two measures are created with that in mind. They're intended to make care better, to provide an opportunity to systematically capture data, which may be used for accountability, but more importantly, can be used for learning and moving the healthcare system forward.

We developed the evidence for this predominately for the components of the measure, but because of both the constraints in terms of number of submissions that we could offer, based on what the contract that NQF had, and based on the way that NQF advised us with regard to bringing things together, we present this as a composite.

We think it stands well as a composite. We also think it would stand well -- its component measures stand well on their own.

And we're happy to discuss with the Committee what meetings their pleasure, their future pleasure.

This is intended to be a population- and plan-level document, but it was not thought of specifically as a -- not as a practice or a hospital measure. It really requires some aggregation of numbers to be there.

I regret that we don't have some of the data that I had intended to be able to share with you because of a combination of IRB arcana related to my move to Case Western, which pushed what should have been a routine IRB renewal into the months to get approval.

And then our partner at New York State who was doing analysis is leaving for paternity leave, ironically enough. He is back in the office as of today, although I haven't been able to speak to him today. I had hoped to, but I wasn't able to reach him.

So we realize there's some reliability data that we had intended, that we think would

enhance the measure. We hope that you will find this attractive enough to move it forward, even if there's some things that we have to do and obligations to provide you before any kind of final action.

The measure is intended as a connection with primary care, so this is not talking about specialists, but really the primary care clinician and their role in -- we're trying to capture that construct of connectedness, even though we recognize that some of the aspects of this might be handled by others, but the prior visit with the primary care doctor is a key component of that. We don't care about who prescribes the medications that we talked about.

There was some discussion of the definition of asthma. We use identifiable asthma according to criteria developed very specifically by our expert panel using a RAND/UCLA modified Delphi method.

Any prior hospitalization with asthma as a primary/secondary diagnosis, one or more

prior ambulatory visits after the fifth birthday with asthma as the primary diagnosis, two or more ambulatory visits with asthma as a diagnosis, or one ambulatory visit and one asthma-related prescription. So this is accounting for those who might be a little younger. There would be, under five, there would be an additional requirement for a visit or a prescription.

Asthma-related medicines were carefully defined and exclude leukotriene inhibitors, since they may or may not reflect asthma. And the purpose here was to not hold people accountable for people who may or may not have asthma, but to identify those whom the plan ought to know and be managing for asthma.

CO-CHAIR CASEY: Dr. Kleinman, I don't mean to interrupt you, but we are limiting the presentations from our measure developers, and I think the Committee has mulled over a lot of what has been provided already and is aware of much of what you're speaking.

I think the concern during the last

discussion was whether there's any additional evidence that you could provide for this measure, since you submitted it? That's really, I think, one of our key issues here.

DR. KLEINMAN: So one of the things --

CO-CHAIR CASEY: So be very brief, please, because we --

DR. KLEINMAN: Got it.

CO-CHAIR CASEY: Thank you.

DR. KLEINMAN: I will do. So we do not have the plan-level and the county-level data that we had intended to have. That was the issue that I referred to was delayed because of IRB and then a subsequent paternity leave.

What I do have is some information that's actually in the other measure, but relates to the definition of identifiable asthma, and I thought I should bring this to your attention.

Which is that if you look at proportion of children who get inhaled corticosteroid prescriptions or controller medication prescriptions following an ED visit,

those who have identifiable asthma, it was about 35 percent, 34.4 percent.

Those without identifiable asthma, it's about 13.5 percent, which I think provides some clinical validation of the construct that we use for identifying identifiable asthma as being meaningful to those in practice and manifest with actual behavior differences among practicing and among the management of these children. So I think it supports the identification piece. What we don't have --

CO-CHAIR CASEY: So, you're referring to 3171, then, in this second --

DR. KLEINMAN: I'm saying that the 3171 submission includes that, but it's --

CO-CHAIR CASEY: Yes.

DR. KLEINMAN: -- actually relevant validation for 3170 --

CO-CHAIR CASEY: Okay.

DR. KLEINMAN: -- that we did not --

CO-CHAIR CASEY: Okay. Thank you. Thank you very much. Okay. So why don't we hear

from Ryan, who was the lead on this one?

MEMBER COLLER: Yes, and I'll certainly invite Emma and--

CO-CHAIR CASEY: And we're going to speak first about Evidence, right?

MEMBER COLLER: Yes.

CO-CHAIR CASEY: This is the must-pass requirement?

MEMBER COLLER: Right. Correct. Congratulations, Dr. Kleinman, and best wishes to you and your family. And thank you for amassing a tremendous amount of information and background evidence on the asthma measures, much of which, I think, is from the EPR-3, Expert Panel Report 3, that was conducted in 2006, that really lays out the evidence-based clinical practice guidelines for asthma management for children.

And I was about to say, inviting Ellen and Emma to jump in at any point. I'll just really quickly summarize what the measure is for folks, just to get us back on the same playing field.

So among children who are between 2 and 21 years of age who've had an ER visit or hospitalization for asthma, it's looking back and saying, in the six months prior, did you have a PCP visit? Did you have a controller medicine prescription? And then, over the 12 months prior, did you have a short-acting beta agonist prescription?

And it's a composite process measure, so you have to have all three of those in order to meet the measure. And I'll start by just a really brief evidence review, and then maybe ask a few questions and bring up a few points that relate to my interpretation of the evidence.

So first of all, if you think about each item one at a time, the EPR-3 was built on a pretty robust systematic literature review and includes Grade A evidence to have children with asthma managed with short-acting beta agonists and asthma controller medications.

So, with respect to the spirit of what's in those two pieces of the component,

there is high quality evidence to say that those are appropriate treatment modalities for asthma. Visits to a primary care clinician are recommended but based on lower quality evidence, not randomized controlled trials.

I think one of the challenges of linking and extrapolating what's in the evidence from that systematic literature review is that, inherent to a lot of the research on the effectiveness of beta agonists and controller medication for asthma, there are several other components which are difficult to measure not included in this measure that probably relate to the evidence to support those medications to prevent asthma outcomes like ER visits or hospitalizations.

So that's things like asthma action planning, education. And throughout the evidence review, there's reference to some of those other components to support the evidence for this measure, but I think it's difficult to extrapolate in some cases that piece of the

evidence base.

In looking at these prescriptions in isolation without thinking about appropriate use, communication, education, and asthma action planning, is a little bit difficult and requires a little bit of a leap, but I think in the spirit, the evidence to support those medications for managing asthma and preventing asthma-related ER visits or hospitalizations is very strong.

So, I agree with the measure developers on that point. Just a couple other things to mention about the evidence to date. So, the systematic literature review for EPR-3 goes through 2006, so it's a little bit over ten years old.

There is additional literature provided by the measure developers in the packet of information, done through thorough literature review, not systematic literature review per se. And as Dr. Kleinman mentioned, there was a lot of multi-disciplinary input into the process for generating the evidence for this measure.

So a couple of quick questions I wanted to bring up and ask Dr. Kleinman and bring up for discussion. One is related to a little bit of a conundrum on the measure itself. So the evidence base would suggest, if we have children taking short-acting beta agonists and controller medicines, that they would have fewer ER visits or hospitalizations.

The denominator for this measure is having an ER visit or a hospitalization for asthma. So if we're doing really well on this measure, all of our children should be getting beta agonists and controller medicines and having primary care follow-up, but at the same time, to get into the denominator for this measure, they would be having an ER visit or a hospitalization.

So there's a little bit of a cross-points there in sort of attention between the outcome we're trying to prevent being the denominator for the measure itself, if I'm articulating that clearly. So, if we're performing at 100 percent on this measure, we

still do have ER visits and hospitalizations for asthma.

So that's a little bit of a challenge, I think, to discuss. And I was curious, with that in mind, why the denominator wasn't, instead of children with an ER visit or a hospitalization and looking back over the past six to 12 months, why wouldn't it be all children with asthma and seeing if they're having the management that the evidence would suggest that they have?

DR. KLEINMAN: Sure. So I actually love the question. First of all, these are two measures of a suite of five asthma measures that we have developed. And two of them are currently under review in the pediatric progress.

One of which is a count of the number of ER visits or ER visits and hospitalizations, which we combine them, really, as a proxy, because that's what you have to do to get close to the number of ED visits, because of the way that billing works.

So we do have an independent count, or

really it's a rate, of ED visits per hundred child-years. So I think that this is best understood in conjunction with that measure, but know that that's there.

We also have a measure that assesses whether or not the appearance in the emergency room actually reflects a clinical circumstance for which the ED is an appropriate level of care, because of course you can have people coming for lots of other reasons.

So we think that actually in their entirety, this suite of measures provides a 360 degree view of what's happening for those in the emergency room. The reason we did it this way was two-fold.

One is it gives a point of reference for the time frame for the visits before and the medications before. You could look at periodicity of prescribing, and there are other things you can do. But what we were asked to do by AHRQ and CMS, specifically, was to develop a measure related to overuse of ED visits for

children with asthma. So therefore, that really was the touch point, the ED visit.

In some ways, this is looking at, you might think of potentially preventable or routinely preventable ED visits, if they don't have these very basic and relatively soft standards for coordinated care: the follow-up; one controller medication six months, which, in theory, you could make it one month and it would be a stricter, sharper, probably more strictly adherent to the guideline measure; and the one short-acting beta agonist.

By the way, we got the time frames from our expert panel. That was all part of the development work, and then our stakeholder group reviewed and was comfortable with it. Does that answer the question? If not, I'm happy to have you clarify or ask for deeper response.

MEMBER COLLER: I think it does. I think it challenges understanding what the measure can tell us. So, if a patient is receiving medication fills that we can detect by

the measurement, but they're ending up in our denominator because they had an ER visit or hospitalization, they did well on the measure, but they did poorly by their asthma outcome.

Which is just a tough thing to sort of deal with, and I think it reflects the fact that it's hard to measure all the other pieces that we all know and agree are important to asthma management.

So, I think it's a challenge with the state of the art, but also makes the interpretation of the measure one level of sort of nuance that's hard to rectify. Can I ask one other quick clarification question?

DR. KLEINMAN: Sure.

MEMBER COLLER: So this is a patient-level measure, right, not an event-level measure? So patients are only in the denominator once, and it's their first visit, and then looking back from that visit, that would be included? Is that accurate?

DR. KLEINMAN: That's right. And

that's actually because of data issues regarding, how do you interpret it if someone's been in the ED a week earlier? Is this now continuous care? Is it some coordination? Were they supposed to have come back? To us, it muddied the waters in terms of what it meant and the overlapping time periods.

For the asthma rate measure, it counts all visits, so it's actually a rate, not a risk. This is really using an index visit to assess this. And the first visit would be the one that tells whether there was adequate performance before whatever cascade of failures that resulted in the ED visit started.

CO-CHAIR CASEY: Ellen and Emma, do you have any additional thoughts?

MEMBER SCHULTZ: I'm just curious to hear from the group what you think about this, because the three of us had quite a bit of discussion, and it was Emma, I think, who first brought up this issue.

We've been sort of scratching our head

around, on the one hand, this measure is trying to connect the dots, and it's fairly innovative in looking back to connect the dots of what care happened beforehand, whereas typically, we look at follow-up after and index event.

But much like Ryan, I'm sort of troubled with the notion that you could perform very well on this measure -- you're doing all those things beforehand through medication and primary care -- but you still have kids ending up in the ED for asthma.

And as we have broader conversations in the measurement world around wanting to move more towards outcomes, I'm troubled by the idea that the outcome we typically want to prevent is the denominator, and yet you can still be successful in the measure --

CO-CHAIR CASEY: And are we really --

MEMBER SCHULTZ: -- even when there's cases there. Are we really --

CO-CHAIR CASEY: How well are we measuring care coordination because of that,

right?

MEMBER SCHULTZ: Right.

CO-CHAIR CASEY: Emma?

MEMBER KOPLEFF: Yes. I'm appreciative of the clarifying comments around sort of the lens by which this measure was developed. Hearing that it was developed through the lens of overuse was a little bit of an aha moment for me in terms of why was it done this way, but it doesn't quite satisfy my concern that I share with my co-reviewers around the outcome we want to measure or to be able to connect this measure to to improve care coordination.

I know another measure, as part of this suite, that is not in front of us was mentioned, and perhaps as a discussion of gaps or for future consideration for the developer, it would be sort of interesting to -- it's hard to evaluate that without having that in front of us, but it was of interest.

CO-CHAIR CASEY: Well, we'll put a placeholder on that for our gaps discussion,

okay?

DR. KLEINMAN: Is it okay --

CO-CHAIR CASEY: Sorry, Dr. Kleinman --

DR. KLEINMAN: -- for me to --

CO-CHAIR CASEY: Dr. Kleinman, I'm sorry, we're in the Committee right now.

DR. KLEINMAN: Okay.

CO-CHAIR CASEY: Other members of the Committee who wish to comment on this? Ryan, do you -- your light is on.

MEMBER COLLER: Yes. Well, I can bring us back to the evidence conversation. I think, in general, the evidence, again, to support the individual items is built on a strong literature review and attempts to really link important aspects of guideline-based care for asthma and measure them.

And so I think the preliminary assessment for the strength of the evidence on this was moderate, and I think that's largely because of the fact that there hasn't been a systematic literature review specifically on the

items within the measure, and so I think that that seems appropriate as well.

And I think, as we continue the conversation into reliability and validity and gaps, we can bring up some of the other general questions we have with respect to the measure, because there's a few others that we can talk about.

CO-CHAIR CASEY: So you're really addressing the notion of a composite measure here?

MEMBER COLLER: Yes.

CO-CHAIR CASEY: Yes, right. Emma?

MEMBER KOPLEFF: And I'm just seconding Ryan's assessment, where it seemed like the group was in our Committee call, and where the three of us landed was, although there are concerns on importance only, I landed in this sort of moderate space of, there are concerns, but there was also a lot of work done, and appreciate the developer's efforts in terms of the literature review and the data they used to demonstrate

importance.

CO-CHAIR CASEY: Other Committee members? So, Dr. Kleinman, I will ask for your final last word, but let me ask Yetunde, our next task is to vote, right?

MS. OGUNGBEMI: Right.

CO-CHAIR CASEY: And remind the Committee, we're going to vote on the evidence, right?

MS. OGUNGBEMI: Yes.

DR. BURSTIN: Don, while she's pulling that up, I remembered something from the preliminary analyses about the question of the evidence for the time frames. Again, that's part of the measure and I saw it raised in the work groups, so if the lead discussants can mention that.

CO-CHAIR CASEY: Thank you, Helen.

MEMBER COLLER: Yes, I -- oh, sorry.

CO-CHAIR CASEY: Go ahead.

MEMBER COLLER: I agree that there is not a strong evidence base for the frequency of

follow-up, but there are recommendations within the guideline, and six months sort of captures everything shorter than that as well, which I think is where some of the question is, should it be as long as six months, or shorter? I think that the strength of the evidence on that item is part of what brings it -- what would limit it to being moderate as well, even if there was a systematic literature review.

CO-CHAIR CASEY: So, Yetunde has the vote up and ready. Dr. Kleinman, do you have any last comments, brief, before we vote?

DR. KLEINMAN: Sure. I think one of the things that this measure is attempting to answer is the question of whether failures of care coordination are a major source, or to what extent it's a source contributing to ED visits and hospitalizations, since other sources could be things like asthma severity, failure to have plans within the care, asthma action plans within the care, environmental and other non-clinical exposures. I would say that it was -- concur

that it was Class B evidence for the six months.

And when we looked at the data, and I think this is in the presentation that we prepared for you, while we found that 28 percent had a visit within six months, 18.5 percent were within four months; 11.9 were within three months. Our Committee was comfortable with all of those. We went with the six months because it was in the asthma guideline --

CO-CHAIR CASEY: Thank you.

DR. KLEINMAN: -- and --

CO-CHAIR CASEY: Thank you.

DR. KLEINMAN: Thank you.

CO-CHAIR CASEY: So, Yetunde, we're firing up our clickers?

MS. OGUNGBEMI: Yes.

CO-CHAIR CASEY: Is that what we're doing?

MS. OGUNGBEMI: Yes, sir. We are now voting on Measure 3170 on evidence. This is the Proportion of Children with ED Visits for Asthma with Evidence of Primary Care Connection Before

the ED Visit. Your options are: 1, high; 2, moderate; 3, low; and 4, insufficient. Voting is open.

CO-CHAIR CASEY: Our two members on the line, are you there? Vote?

MEMBER HOHL: This is Dawn. I did vote. Did it not come through?

CO-CHAIR CASEY: Not yet, Dawn. It looks like you got disconnected for a bit. Yes, we got you. We got both, right?

MEMBER HOHL: So you do have it? Okay, good. Thank you.

CO-CHAIR CASEY: Thank you.

MS. OGUNGBEMI: Our results are: 1 vote high, 10 votes moderate, 5 votes low, and one vote insufficient. 6 percent high, 59 percent moderate, 29 percent low, and 6 percent insufficient.

Because we did reach 60 percent, we did not reach consensus, so this measure falls in the -- oh, I'm sorry, I'm looking at 59. Yes. I've got it. Pardon me, I'm sorry. Measure 3170

passes on evidence.

CO-CHAIR CASEY: Thank you. So let's proceed with our next discussion.

MEMBER COLLER: Performance gap?

CO-CHAIR CASEY: Yes.

MEMBER COLLER: Yes. So, the measure developers have provided some information from an analysis of New York State Medicaid data that showed 16.5 percent of children with the definition for asthma used by the measure achieved the composite measure, having the visit, the short-acting beta agonist, and the controller med. And there was -- so there's definitely an opportunity for improvement.

The data is entirely from Medicaid. It's not entirely clear to what extent that will translate or differ among children who are commercially insured, but that said, I would anecdotally expect there to be a gap there as well.

In addition, there are gaps and disparities in race, ethnicity, urbanicity, and

poverty for performance on the measure itself. And the range of performance looked, to my eye, to be between about 8 percent at the low end and maybe 20 percent on the high end for performance of this measure across different subgroups of children.

A couple of other pieces that sort of fit within this were, the measure really only applies to children with persistent asthma, which is important, I think, for all of us to remember. And a question that I had, and I don't know if we have any data on this, is to what extent children might change over time, because I would expect, we're looking at a patient-level measure, but their experiences with care probably do change over time. I don't know if the developers have had a chance to look at that.

And then, comments from the pre-meeting. Just a question, and I think we heard a little bit of this at the intro, was whether or not the 3171 measure number was the same as what we're seeing in this, whether there was an error

potentially in 16.5 percent performance, baseline performance, in either this measure or the other one. I think we heard some clarity around that. And I think I'll stop there, unless -- let's see if my partners have comments, too.

MEMBER SCHULTZ: I want to just add to that that, while the overall performance was 16.5 percent, there also is some data on stratification that was included sort of deeper in the packet. And personally, I found that really useful as well.

And I heard Dr. Kleinman say at the beginning, the decision was made to put this in as a composite but that you also could take the individual pieces of this and either use them individually or sort of look at it in a stratified way.

To me, that's a strength of this measure, that you actually could get some really actionable information, to be able to look at the strata and see, for a particular population, maybe the performance is quite good on

prescriptions, but it's the primary care visits where you have the biggest gap that's occurring.

And so that naturally leads towards some quality improvement action. And so I see that as a strength, and I think that it's something that should be continued. And so just having the all or nothing composite, to me, isn't nearly as useful as being able to see that broken out.

CO-CHAIR CASEY: Emma?

MEMBER KOPLEFF: Just one comment to Ryan's thought about the Medicaid data that was used for the preliminary analysis. I did also appreciate the developer's note about the 60 percent of children with asthma who have public insurance. So for me, that was satisfying, along with the anecdotal, if you will, or expert opinion thoughts about applicability to the general population of children with asthma.

CO-CHAIR CASEY: Any other questions from the Committee? Ryan, you have your mic on? Okay. Yetunde, are we voting on this?

MS. OGUNGBEMI: Yes.

CO-CHAIR CASEY: Yes. So let's get your clickers ready again.

MS. OGUNGBEMI: We are now voting on performance gap for measure --

CO-CHAIR CASEY: Sorry, Rich.

MEMBER ANTONELLI: I apologize. Ryan raised the issue about the 16.5 percent. Did we get a response to that? The 16.5 percent number that appears in the data submission for both of the measures? So I didn't hear it if it was proffered.

MEMBER COLLER: I'll defer to Dr. Kleinman. I thought I heard, maybe, there was a corrected number that was somewhere in the 30 percent range for the baseline performance of 3171, but I defer to him to clarify that.

CO-CHAIR CASEY: For 3171? Okay, we're on 3170 right now.

MEMBER COLLER: I think the question was --

DR. KLEINMAN: So I'm actually -- what

I have in front of me, just because it's what I had been focusing on earlier, is the various component measures. But, yes, this is -- I believe this one was 16.5 percent, and the other was substantially lower, 3171. So if we put them together, I'm sorry, that was in error.

And for this, for the various components, we had 72 percent with a short-acting beta agonist, 28 percent with a primary care visit, and 25.8 percent with a controller medication. 23.3 meeting both medication criteria, 18.7 percent having met no prescription, and 64.4 percent did not meet either medication criteria, six month primary visit. But what I don't have on this page, and I'm sorry, but it's probably what the 16.5 percent that's elsewhere, was the overall composite.

CO-CHAIR CASEY: You good, Rich?

DR. KLEINMAN: But the numbers are substantially different from the other measure.

MEMBER ANTONELLI: I guess I just

wanted to know what we were voting on. So, Dr. Kleinman, are you saying the numbers that we have in our presentation are the correct ones for 3170?

DR. KLEINMAN: I believe that they are, yes. I will tell you, I have read but not studied this document in prep for this meeting now, because of competing priorities. But I believe that it's correct.

Certainly, the numbers that I just gave you for the various components of them, 28 percent primary care visit, 72 percent short-acting beta, 25.8 controller prescription, 23.3 percent both medications, and 18.7 percent no medication, and the 64.4 percent did not have both medications and had no visit, are accurate.

I could parse that. It may take five minutes of algebra and maybe a sharper brain than I have at the moment, and give you that number and say that's 16.5 --

CO-CHAIR CASEY: Dr. Kleinman, I'm sorry, I think we're going to go with what we've

got. Thank you.

DR. KLEINMAN: I think that's fine.

CO-CHAIR CASEY: Thanks. So Yetunde?

MS. OGUNGBEMI: Yes. We are now voting on performance gap for Measure 3170. Your options are: 1, high; 2, moderate; 3, low; and 4; insufficient. Voting is open.

Results are: 4 votes high, 11 votes moderate, 1 vote low, and 1 vote insufficient. We have 24 percent high, 65 percent moderate, 6 percent low, and 6 percent insufficient. Measure 3170 passes performance gap.

CO-CHAIR CASEY: Thank you. Ryan, you want to keep going? Or is -- Ellen's going to take over here. Thank you.

MEMBER SCHULTZ: I'm going to take over for the reliability and validity. So, I think my overview will be quite brief. As Dr. Kleinman --

DR. TERRY: Excuse me. There is the 1C, which is a construct, and it is must-pass criterion. So, it's quality construct.

CO-CHAIR CASEY: Thank you.

DR. TERRY: Thank you.

CO-CHAIR CASEY: I'm sorry.

DR. TERRY: That's okay.

MEMBER SCHULTZ: Okay.

CO-CHAIR CASEY: You want to cover 1C, or is that still Ryan?

MEMBER SCHULTZ: Okay. So --

CO-CHAIR CASEY: Briefly.

MEMBER SCHULTZ: So, we're going to vote on 1C. So, I think here, this is where we're considering, do we agree that the construct as a whole is important? Okay.

CO-CHAIR CASEY: Right.

MEMBER SCHULTZ: So, I think --

CO-CHAIR CASEY: And this is a must-pass.

MEMBER SCHULTZ: And this is a must-pass. So, I think, we did have some discussion earlier about sort of the numerator and the denominator, and you all heard from Emma and Ryan and I in terms of our thoughts on that. I shared my thoughts earlier about the stratification and

the value, being able to see that level of detail, so I don't think I have too much more here to add.

I'm a little surprised that we didn't hear from the Committee around the issue of the construct itself, so maybe now is the chance, if you've reflected a little, how others feel about the value of this? And is it important to look at these events that precede ED visits for asthma, and is that something that's useful?

CO-CHAIR CASEY: Committee members? Yes, Shari, do you --

MEMBER ERICKSON: Sorry, I thought there were comments in the worksheet, just, it looks like three or four on the Construct about it.

CO-CHAIR CASEY: Did you see those comments?

MEMBER ERICKSON: Those are from the Committee, right? In our pre -- okay.

CO-CHAIR CASEY: Yes.

MEMBER KOPLEFF: Could the staff help

us out a little? Ellen and I were talking about navigating the SharePoint to get to what Shari's looking at. So, if --

MEMBER ERICKSON: I had help today.

CO-CHAIR CASEY: The screen. Emma, it's up on your screen to your left --

MEMBER KOPLEFF: Okay.

CO-CHAIR CASEY: -- or in front. Yes.

MEMBER SCHULTZ: Okay. So, as I just said, there was some discussion during the work group, and what's shown here on the screen that isn't all or nothing the way that we should go? For my part, I'll just say that, if that stratification level of detail is bigger, then I feel like that's enough, but I could be persuaded otherwise. And then someone, other questions were raised about, is it setting the bar too high to have these three different pieces? So a similar question around all or nothing.

CO-CHAIR CASEY: Dr. Lamb?

CO-CHAIR LAMB: I think you raise really good points. It strikes me that, first

off, this is coming forward as a care coordination measure. And it's an interesting combination of connects between what happens prior, but the selection of the drugs makes it more of a clinically-focused rather than the connect with the care coordination.

So, I had similar questions about it. Is it the composite of care coordination? I think Ryan raised really important points about, what would make this a composite care coordination measure that really looks at the core components of what makes something a care coordination process? So for me, the drug measures aren't as good a fit for a care coordination measure.

CO-CHAIR CASEY: Terry?

MEMBER O'MALLEY: Yes. To follow-up on that comment, sort of missing from the asthma intervention plan are all the pieces that weren't mentioned before: the environmental input, smoking at home, that's -- all of the things that, particularly in populations with

disparities of care, seem to be more prevalent. It makes me just wonder whether the composite needs to be broader rather than more constricted.

CO-CHAIR CASEY: Barbara?

MEMBER GAGE: Not having a background in medicine, but in thinking about it from a research approach and the identification of the population, the evidence that they supported for why these factors seemed to select those cases where you would expect a high-risk population.

So it may not be inclusive of everybody with asthma, but you want to be sure that if you're thinking about performance, that you're holding -- you're measuring that which, where you expect a change. And so I thought that the identification made sense.

It wasn't all-inclusive. I'm sure there are other factors out there to consider, but even if you had those, they could be co-linear, so you might just be measuring the same thing you're picking up with the ones you have.

CO-CHAIR CASEY: Karen and Brenda, I

know you're at the ends of the table, but I can see you, and I just didn't want to put you on the spot, but I wanted you to know, if you want to say something, I can see you.

MEMBER MICHAEL: I like to put my card up when I speak. It's a little bit of a challenge today.

CO-CHAIR CASEY: No problem.

MEMBER MICHAEL: But with respect to this particular measure, I agree that the composite probably should be broader, but I think it's at least a place to start.

CO-CHAIR CASEY: Thank you. Brenda?

MEMBER LEATH: And thank you for noticing that I was trying to figure out how I was going to make my statement. I think that this is a very good approach to a measure around this, because I think, yes, there are some clinical components to it, but I think knowing what were the precipitating factors that led to the ED visit is important.

And there is a role for care

coordination in that. So I think that, yes, I've been pondering, like, what I might have done differently, but I think that this is a good start.

CO-CHAIR CASEY: Rich?

MEMBER ANTONELLI: So I'm grappling with a couple of issues, and I don't have clarity yet. But one is the question of, and I think, Ellen, you raised this, does it makes sense that this is a composite, yes or no?

And we could go on the no, and Terry would argue that it needs to even be a broader composite. So, I'm a little bit -- I'm thinking deeply about that. But the second piece is, are -- do we have the right elements in the composite, right?

So to the degree that we have visits that would be captured in claims to primary care provider in a pretty broad window, the presence or absence, for example, of an asthma action plan or what happened within those primary care visits, if the child just came in and got their

tetanus shot and their BMI checked, they would get credit, but if the issue of asthma didn't get raised -- so, I don't know if this is a question for the developer or whether the discussants can address this.

Why do we not see in the composite the presence of an asthma action plan? Just to throw something really granular out there. Is it fair to ask the developer --

CO-CHAIR CASEY: Well, I think at this point, the measure is what it is, Rich.

MEMBER ANTONELLI: Yes.

CO-CHAIR CASEY: So, I think --

MEMBER ANTONELLI: Okay.

CO-CHAIR CASEY: -- we should leave it at that.

MEMBER ANTONELLI: Okay. So, then, I, therefore, I struggle with -- so, I'm actually -- I'm going to argue that the composite measure itself stretches my ability to adopt it. I do think that there is value in looking at these components, as Ellen has pointed out, but I, for

one, struggle in terms of the face validity of a visit to a PCP that doesn't tell me what happened.

CO-CHAIR CASEY: Helen, do you --

DR. BURSTIN: Just a couple of quick comments. So, to Gerri's earlier point, this measure doesn't have to fit squarely into the care coordination box. We put it here because it seemed like care expertise would be useful, but I don't want people to feel like that's a requirement.

But secondly, I just pulled up our Composite Measure Evaluation Guidance, just to sort of remind us what quality construct means, because we're kind of talking about it in these generalities.

I mean, the expectation is, the components are included, that you should think about, are they the right components, exactly the questions you've been grappling with. How the components are aggregated and weighted, so you haven't talked very much about the all-or-none,

that would be part of this quality construct as well.

You'll get to talk soon about the analyses, in terms of looking at reliability and validity. But finally, I think really importantly, does this add value over the individual measures alone? So I just want to put that out there for your consideration.

CO-CHAIR CASEY: Thank you, Helen.

DR. BURSTIN: Yes.

CO-CHAIR CASEY: Someone over there wanted to talk? No? That was a good insight.

DR. KLEINMAN: Yes. This is Larry, can I respond to one thing, because I think there was a --

CO-CHAIR CASEY: I'm sorry. Barbara, did you have your hand up? Or no? Okay, go ahead, Dr. Kleinman.

DR. KLEINMAN: Okay. Thank you. I just wanted to clarify that, for this measure, it does have to have asthma as a primary or secondary diagnosis for the primary care visit.

So it's very specific that that was an important component of the visit.

And secondly, just to say the specific reason we didn't have something like an asthma action plan is because it requires a different data source. It requires a chart, and that's a whole different animal in terms of feasibility.

The third thing I would say, in relation to the comment about the medication, we also did some work on medication reconciliation in the CAPQuaM. And one of the things we've come to realize is that medication management and the capacity to follow-up and know if your patients are filling their prescriptions and to act on that information really is the role of a medical home.

So we would argue that that, in addition to it being independently important, it actually, if someone is not filling their medications, and the medical home or the primary care is not acting upon that, that's actually a part of a failure to fully coordinate care.

CO-CHAIR CASEY: Thank you very much. Any last thoughts before Yetunde fires up the vote machine? All right. So Yetunde, it's all yours.

MS. OGUNGBEMI: We are now voting on the composite 1C for Measure 3170. Your options are: 1, high; 2, moderate; 3, low; and 4; insufficient. Voting is open.

CO-CHAIR CASEY: And this is a must-pass, right?

MS. OGUNGBEMI: Yes. Results are: 1 vote high, 10 votes moderate, 6 votes low, and 0 votes insufficient. 6 percent high, 59 percent moderate, 35 percent low, and 0 percent insufficient. Measure 3170 passes the composite.

CO-CHAIR CASEY: Thank you. Great. Just like, it looks like the first vote. Okay. Ellen, are you continuing?

MEMBER SCHULTZ: I am continuing. So next up is reliability. Okay. So, I'm going to keep my comments brief, because there was no reliability testing data provided. As Dr.

Kleinman said at the beginning, that was something that they were hoping to be able to provide and were not able to do so.

This is a must-pass criterion, and so we can follow our little algorithm and see that it points us in that insufficient space. I do want to have an opportunity here, though, to hear from folks.

Do you have other concerns related to reliability? Or questions? Because I think that's something that would be useful to discuss and for Dr. Kleinman to take back in terms of further work on this measure, regardless of how the vote turns out.

CO-CHAIR CASEY: Agree. The other reviewers care to add to Ellen's?

MEMBER KOPLEFF: I was hoping we could just get a response from Dr. Kleinman about the anticipated timeline for producing those results.

CO-CHAIR CASEY: Ryan, do you have any?

MEMBER COLLER: I just was curious to what extent there might be data to look at, you

know, some of the performance on this measure might be low because much of the child's asthma care is through a pulmonologist or an allergist or somebody for whom a PCP may not actually have a qualifying visit, but their care still might be quite good. And then --

CO-CHAIR CASEY: So Ryan, just to be sure I understand your question, you're looking for published data?

MEMBER COLLER: No, whether they have, I guess, internal --

CO-CHAIR CASEY: Whether they've had preliminary data?

MEMBER COLLER: An opportunity that --

CO-CHAIR CASEY: Okay, thank you.

MEMBER COLLER: -- would provide support --

CO-CHAIR CASEY: Thank you.

MEMBER COLLER: -- for the reliability of the measure. And the other is, low performance on the measure might be due to including children who have intermittent asthma,

for which a controller medication wouldn't be indicated. So also curious if that data might exist.

CO-CHAIR CASEY: I think what I'll do is ask the Committee if they have, because you want Dr. Kleinman to respond to these, but does the Committee have any other thoughts at this point about what you've heard?

I know you're anxious to hear Dr. Kleinman's response. Does anyone want to add anything? No? So, Dr. Kleinman, if you could be brief in responding to the reviewers' quick questions, we'd appreciate it.

DR. KLEINMAN: Sure. I don't have the data in front of me, but we did look at the numbers with any visit, I don't think we even restricted it to a pulmonologist, as a part of our early development work.

And the numbers, while higher, were not appreciably higher. There still were large gaps. So I don't think that that pulmonologist would fix it. I'm sure we could dig that data

up, but I just don't have it in-hand.

In terms of persistent asthma, the construct our expert panel had in mind when defining these criteria was in fact persistent asthma. We chose to use the term identifiable asthma to not confuse it with the HEDIS measures of persistent asthma, since we were, NCQA was a partner in our work, and we didn't want to invite confusion there.

I will tell you that, if you look at the population in New York State who have any kind of asthma diagnosis, you'll find about 14 percent, 13 to 14 percent have an asthma claim, 15 to 16 percent will actually say on a survey that they have asthma, the CAPQuaM measure will identify 8.6 percent with identifiable asthma, and the HEDIS measure will identify between 3 and 4 percent as having persistent asthma under those very strict criteria for their hospitalization measure.

CO-CHAIR CASEY: Dr. Kleinman, so I think the answer, basic answer is, you're still

working on generating the reliability data, as I understand it. Is that correct?

DR. KLEINMAN: Yes. And the answer in terms of the time frame is, the basic programming is done. The programmer returned from paternity leave today, or at least his out-of-office says he is returning today.

We think we can have it in a fairly timely fashion. I'm sure he's got other things on his desk. But it's being -- the work is being done by New York State Medicaid. We don't actually own the data; they're analyzing the data for us.

So we don't have full control, but now that we have the other kinds of approvals in, and I got word yesterday that the IRB issue, they finally figured out that I am both at Mount Sinai and at Case Western, since I have an adjunct appointment --

CO-CHAIR CASEY: Okay.

DR. KLEINMAN: -- the IRB struggled with that for some months without actually

communicating that.

CO-CHAIR CASEY: Okay, thanks. I think that the good news here is that there will still be a window of opportunity for you before we have the end, the close of public comment, to bring data to the table. But today, we don't, so that's what the Committee is going to have to vote on. Am I right, Yetunde?

DR. KLEINMAN: Right. And I would ask --

CO-CHAIR CASEY: So, I'm sorry --

DR. KLEINMAN: -- that it be --

CO-CHAIR CASEY: I'm sorry, Dr. Kleinman, we're going to proceed now, and we're going to ask Yetunde to get your clickers in place so we can move on. Okay. So we're now voting on reliability.

MS. OGUNGBEMI: Yes, sir. We are now voting on reliability for Measure 3170. Your options are: 1, high; 2, moderate; 3, low; and 4, insufficient. Voting is open.

CO-CHAIR CASEY: And this is must-pass

as well.

MS. OGUNGBEMI: Results are: 0 votes high, 2 votes moderate, 1 vote low, and 14 votes insufficient. Percentages are: 0 percent high, 12 percent moderate, 6 percent low, and 82 percent insufficient. So Measure 3170 does not pass on reliability.

CO-CHAIR CASEY: And therefore, the measure does not, at this point, pass for recommendation, am I right? But is still subject to this window that we mentioned to Dr. Kleinman, which we expect he'll work hard on.

And I think this is not surprising. I mean, the group that did the primary review did their job, so we appreciate it. And I think the good news is that this was just a hole in the measure, so I think there's still significant opportunity here to come to the table here. And I assume that, so far, the feedback that we've given Dr. Kleinman has been well-received.

Let me ask the reviewers, because they did a lot of work on this, if they want to just

briefly highlight the rest of this review so we can get that on the record. We're not going to vote, as I understand it, Yetunde?

MS. OGUNGBEMI: Yes, sir.

CO-CHAIR CASEY: At this point, but we would like to get it into the record. So, if, between the three of you, whoever wants to carry us through to the end can just briefly summarize your thinking on the rest of the criteria? If that would be in order?

MEMBER SCHULTZ: Sure. So I'll finish up on validity and then hand things over to Emma. So very briefly, on the validity, they presented evidence from the literature to support each of the individual data elements, which is one of the ways in which to demonstrate validity.

And so there is a summary that goes with each data element. In reviewing that, it looked fairly solid to me. I certainly would be interested if there are others that have thoughts.

I am not an expert in data on

medication fills, and so that was one question in my mind is, how valid is that to be used for measurement? But there was evidence from the literature that suggested that it was solid. So I think I'll leave my comments there. Unless Ryan or Emma has something more to add to validity, we can move on.

CO-CHAIR CASEY: Emma?

MEMBER KOPLEFF: I concur. There was some detailed information from the developer, and I thank them for that, not just with the literature, but also around their considerations for sort of balancing sensitivity and specificity and why they included hospital visits as part of the measure. And that was logical to me.

MEMBER COLLER: And I'll just add that the expert panel results were pretty compelling in support of the items, too.

CO-CHAIR CASEY: Thank you. Let's keep rolling the tape here. Emma?

MEMBER KOPLEFF: Sure. So, just on feasibility, it seemed logical that the data

required for the measure and administrative data would be easily accessible from either an electronic or not record.

The usability and use section wasn't filled out, so unless I had a downloading error, we didn't have much discussion during our pre-work group call on this either. But it's of particular interest to me, with regard to the discussion we had of this measure at the beginning, which is sort of what does improvement look like?

So I would encourage the developer in future iterations of this to be really clear in their intent around what is the ideal use of this measure, so that those reviewing can understand what improvement looks like with the potentially shrinking denominator.

CO-CHAIR CASEY: I would say I'm of the -- I would speak for the entire Committee in saying this is important for the developer to pay attention to. And we understand some of the limitations about why the data is incomplete, but

just to reinforce that. Samira, did you want to comment?

MEMBER BECKWITH: Actually, I have a question. Will this come back to the Committee after the public comment period? Will we be discussing it again?

CO-CHAIR CASEY: The answer is, yes. Before it goes to CSAC, right?

MS. MUNTHALI: Yes, before it goes to CSAC. So you will adjudicate all of the comments that come in, even reconsideration requests that come in from developers and others, before it goes to the CSAC, and make a final decision on behalf of your Committee.

CO-CHAIR CASEY: With the elegant help of our staff, who will organize those comments. Which can be quite many. So any last comments on -- are you -- Emma, do you have anything more? Emma, Ellen?

MEMBER KOPLEFF: To belabor it, I do think your comments at the beginning, Don, were helpful to us in reviewing this measure, about

thinking about where we are now, where we want to go. We are appreciative of the concept and there's a lot of good work that went into this, but as discussed today, on the individual criteria, we just sort of couldn't get there.

CO-CHAIR CASEY: Great.

MEMBER COLLER: I just don't know where this comment belongs, but the title of the Measure is slightly different than what is being measured. It's not just ER visits, it's also hospitalizations. And I think that should be updated.

CO-CHAIR CASEY: Yes, thank you. Good point. And I think a lot of this discussion, correct me if I'm wrong, with Rich and his group, is going to apply to 3171. Which means that we ought to be able to get to lunch on time, if we're good.

That's not to say we want to stifle any discussion, but I think we're going to, without trying to influence the vote here, I mean, I am from Chicago, get us to where we need

to be. I'll leave it at that. So, thank you, all three of you.

And, Gerri, if you don't mind, I'll carry forward with 3171. And is Rich the lead on that one? Rich? Dr. Kleinman, we'll carry this forward and then we'll give you the last word at the end, okay?

DR. KLEINMAN: I think that's fine. And I would say, I would be very happy if the voting replicated the previous Measure. I know we have work to do in terms of getting you some data on Reliability.

CO-CHAIR CASEY: And you're not even from Chicago. Thank you.

DR. KLEINMAN: I'm from New Jersey, so it's okay.

CO-CHAIR CASEY: All right. Well, I lived in New Jersey too. Thank you. Here we go, Rich.

MEMBER ANTONELLI: If you guys are done socializing, I'll continue to move us forward, because I'm from Boston.

(Laughter.)

MEMBER ANTONELLI: So, Barbara Gage and I are going to tag-team on this. And, Larry, sincerest congratulations to you and your family. Personally and professionally, thank you for this body of work. It really needs to help advance the field. I am going to go relatively quickly.

It is a different Measure, but I'm going to ask Barbara to jump in so we can move through this. So, this also is a Composite Measure, 3171 Percentage of Asthma ED Visits followed by Evidence of Care Connection. And we'll talk a little bit about that.

The numerator statement is evidence of connection to a primary care medical system following an ED visit, that have a primary/secondary diagnosis of asthma, among children. And the denominator is all the ED visits in which asthma was a primary or secondary diagnosis.

Its data source is on claims, level of analysis is at the level of population. The

preliminary -- so, in fact, let me pause for a second. So, 3170 looks back, this one kind of looks forward with that ED event being what defines getting into this denominator for this Measure.

The -- Ryan did a great job of talking about the linkage to the expert panel, so I won't go into that level of detail, but the evidence basically talks about connecting with that primary care provider within a period of time after an ED visit, with a Composite including the asthma controller and rescue medications going forward.

So, the evidence base connects specifically with meds and recommendations to the expert panel recommendations. I -- in fact, let me sort of pause there, because we're going to do this, we're going to chunk this, right? Okay. So, why don't I pause there. Barbara, do you want to weigh in before we open it up for discussion?

MEMBER GAGE: I'll just underscore that

this is the subsequent, the follow-up care. And I thought that was a real strength, that's a measurable, tieable, event.

MEMBER ANTONELLI: Okay. So, any comments or questions from the Committee about the evidence for how this Measure is constructed? In particular, I guess, Ryan and Emma and Ellen, since these are sort of related Measures, anything that you could add, we'd be happy to entertain.

MEMBER COLLER: Just a minor one. I found -- I don't disagree with anything that we've covered already, I'm just -- the question that I had about evidence of filling the controller medicine within two months of an ER visit, what if you don't need it? What if you already have one or something like that?

Is the idea just, we're assuming if you've had an ER visit, you are out of meds and need new ones? I guess, I don't know, that was sort of a conceptual challenge I was thinking about.

DR. KLEINMAN: Is that an invitation to respond?

CO-CHAIR CASEY: We're going to keep going with our --

DR. KLEINMAN: Okay.

CO-CHAIR CASEY: -- questions and then, we'll -- other questions? And, Rich, you don't have the answer?

MEMBER ANTONELLI: For -- so, I --

CO-CHAIR CASEY: For Ryan?

MEMBER ANTONELLI: -- just wanted to entertain that. So, what I was going to say is, I'm not sure that necessarily I would put the discussion for that question in the Evidence discussion, but I would defer to the Chairs that are much more adept at this.

But I do think by the time we start talking about the elements of the Measure, and maybe rolling up to the Composite, I think that's where I'd recommend we have that conversation. But I would defer to the Chairs.

CO-CHAIR CASEY: Are you good with

that, Ryan? Okay, good.

MEMBER COLLER: Yes, sure.

CO-CHAIR CASEY: Good. So, any other questions? We're going to vote on this, right?

MS. OGUNGBEMI: Yes.

CO-CHAIR CASEY: So, Yetunde's got the clickers on notice to click.

MS. OGUNGBEMI: If there's no more discussion, we are now voting on Measure 3171's Evidence. This is the Percentage of Asthma ED Visits followed by Evidence of Care Connection. Your options are: 1, High; 2, Moderate; 3, Low; and 4, Insufficient. Voting is open.

CO-CHAIR CASEY: Must-pass. I tried to steal Gerri's clicker so I could vote early and often, but she got it from me.

MS. OGUNGBEMI: Results are: two votes High, 14 votes Moderate, one vote Low, and zero votes Insufficient. Twelve percent High, 82 percent Moderate, six percent Low, and zero percent Insufficient. Measure 3171 passes Evidence.

CO-CHAIR CASEY: Continue, sir.

MEMBER ANTONELLI: So, now, we're going to talk about the gap in care and, in particular, the disparities. This is the place where several of us that reviewed these two Measures called out the suspect nature of 16.5 percent.

And that was why, Don, I wanted to make sure that I knew what numbers I was voting on for 3170. So, my suggestion is that we give Dr. Kleinman the chance to comment on this and then the Committee can decide if that's sufficient.

CO-CHAIR CASEY: The other 16.5 percent. And I think he did give us some numbers.

MEMBER ANTONELLI: Yes, the numbers that I think he gave us were primarily related to 3170. But if he conflated them, then I would like to respectfully request he give us the numbers that are specific for 3171.

CO-CHAIR CASEY: And -- why don't we continue through this evaluation, then we can ask

him.

MEMBER ANTONELLI: Okay. So, we're getting into the gaps and the disparities. There was some performance through, collected through data at New York State Medicaid around race and ethnicity, urbanicity, and poverty. And the -- trying to, in my mind, reconcile those numbers is where I'm kind of stuck at this point. Barbara, did you want to add anything to that?

MEMBER GAGE: No.

MEMBER ANTONELLI: Okay.

CO-CHAIR CASEY: So, Rich, let me ask you a question, if it matters. I mean, I might be oversimplifying, but empirically, do you have any reason to believe that these disparities don't exist?

MEMBER ANTONELLI: So, empirically and qualitatively, no, I don't question them. It's the very provocative 16.5 percent in two separate Measures that I'm -- on its face, it actually lacks face validity --

CO-CHAIR CASEY: Right.

MEMBER ANTONELLI: -- to use that term that way.

CO-CHAIR CASEY: Very good. Thank you. Okay. You want to keep -- is that it for this section, the gaps?

MEMBER ANTONELLI: No. And so, I guess I want to make sure that Larry is in the on-deck circle for him to be able to respond. So I do think that, qualitatively, I think the gaps, specifically in the disparities space, are willing to pass muster until I actually hear the real numbers.

I also had the concern, I think I raised this on the prep call a couple weeks ago and I'll bring this back here, is, this is the performance in Medicaid and what would the performance look like in a commercial population as well? And I think that's all I need to bring up right now.

CO-CHAIR CASEY: Great. Good. Any comments from the 3170 club?

MEMBER GAGE: I wasn't that worried

about the data being tied to Medicaid, because I assumed that they would be at higher risk than the commercial population. So, in building the Measure, I thought that was a reasonable approach.

CO-CHAIR CASEY: Thank you. Any other questions from the Committee? Dr. Kleinman, do you want to briefly remind us of the data for this one?

DR. KLEINMAN: Sure. Happy to do that. So, this is what I have in front of me, we have additional, but I'll just give you this. So, in terms of primary care follow-up visit within 14 days after the visit, the number was five percent at the top line, 4.7 percent for blacks, 5.5 percent for whites.

There's similar -- if you use the 30-day stratification, which is just an attempt to illuminate, but is actually not a Composite, since everybody who has a 14-day fits within the 30-day, it would be 7.7 percent, with 7.6 percent for black and 8.3 percent for white children, so

about a ten percent difference. And -- I'm hearing beeps, is that -- you guys hear me still?

CO-CHAIR CASEY: Yes.

DR. KLEINMAN: Okay. So, in terms of controller medications filled within two months, what I have in front of me are the stratified by whether or not there was identifiable asthma. And 34.4 percent of those with identifiable asthma had a controller medication filled within two months and 13.5 percent of those without identifiable asthma.

This was an attempt to get at that issue, well, maybe some of them really don't need it, there was some combination of events that got them in the ED, but it really wasn't that they had this intrinsic need for ongoing management.

So, we wanted to break it out, so that it could be -- I don't have right in front of me, it should be in the packet somewhere, but I couldn't find it on a quick scan, what the actual composite number was when you pull those all together.

CO-CHAIR CASEY: So, let me just --

DR. KLEINMAN: But obviously the numbers are small.

CO-CHAIR CASEY: Let me just ask a pragmatic question for the Staff. Would it be okay if Dr. Kleinman provided us with these data and could we include them?

MS. MUNTHALI: It would be similar to the other Measure. So, you're voting on the Measure -- excuse me, I should be sitting in that corner as well, I have a sore throat. You will be voting on the Measure as it's currently specified. And --

DR. KLEINMAN: If I may, this is actually on 2B4.9 Results of Risk Stratification Analysis. So, these numbers actually were submitted.

MS. MUNTHALI: So, is it -- we're checking here. Do you see it, Peg?

DR. TERRY: I see it.

CO-CHAIR CASEY: You see it? Okay.

DR. TERRY: Can he say them again?

Because I'm not sure they're what I have here.

DR. KLEINMAN: Okay. So, 5.0 percent of ED visits for asthma have follow-up visits with primary care within 14 days after the visit, 4.7 percent for blacks, 5.5 percent for whites.

DR. TERRY: Right. We have those.

DR. KLEINMAN: Okay.

CO-CHAIR CASEY: And this was just in a different section --

DR. TERRY: Yes.

CO-CHAIR CASEY: -- of the --

DR. KLEINMAN: It was just in a different section.

CO-CHAIR CASEY: Yes, okay.

MS. MUNTHALI: Okay. So, then, it sounds like the Committee is fine. Okay.

CO-CHAIR CASEY: Yes.

DR. TERRY: It's 2D.

CO-CHAIR CASEY: Ellen?

MEMBER SCHULTZ: I think the issue for me is that, so you've given what the breakout is that's stratified, but in the separate location,

where you told us what it is when you put the two together, so the number of cases that met both the A and the B criteria, what's stated in this packet is 16.5 percent. And I agree with you --

DR. KLEINMAN: Yes, that's an error.

MEMBER SCHULTZ: Yes. And that's an error.

DR. KLEINMAN: And that's clearly an error.

MEMBER SCHULTZ: But we don't know what the real number is.

DR. KLEINMAN: You're right. I would --

CO-CHAIR CASEY: So, let me just --

DR. KLEINMAN: Yes.

CO-CHAIR CASEY: -- say, for purposes of our vote, do we feel like we have enough information in spite of the imprecision to vote or do you want to keep trying to clarify the data? What's the feeling, Rich?

MEMBER ANTONELLI: I would --

CO-CHAIR CASEY: On the gaps.

MEMBER ANTONELLI: Yes. It's hard for me to vote without seeing the data, because as a reviewer, that's part of what my obligation is --

CO-CHAIR CASEY: Right.

MEMBER ANTONELLI: -- is the due diligence.

CO-CHAIR CASEY: And you have the data that's further down now in the --

MEMBER ANTONELLI: Yes, but --

CO-CHAIR CASEY: -- spec.

MEMBER ANTONELLI: I think the -- I don't think that I've heard the composite data. So, we're being asked to review a Composite Measure and that piece is missing.

CO-CHAIR CASEY: And the way it's presented in this document is the way we have to vote on it. So, okay. It's not reviewable at this point.

MEMBER ANTONELLI: Right. So, it --

CO-CHAIR CASEY: And there's some suspicion about that number, right? Okay.

MEMBER ANTONELLI: Yes. I'm concerned of --

CO-CHAIR CASEY: Right.

MEMBER ANTONELLI: -- without --

CO-CHAIR CASEY: Right.

MEMBER ANTONELLI: -- having that.

CO-CHAIR CASEY: Okay.

MEMBER GAGE: And the Reliability, like, when we get to that on the next, it's the same issue as --

CO-CHAIR CASEY: Right.

MEMBER GAGE: -- with the last one.

CO-CHAIR CASEY: Right. So, do you feel well enough to vote on this now or do we want to keep going? Is anyone --

MS. MUNTHALI: Don, just --

CO-CHAIR CASEY: Yes?

MS. MUNTHALI: -- one clarification. So, we have Karen Johnson here, some of you know her, she is one of our Senior Directors, but also our Chief Methodologist. And so, she's going to shed some light on the all-or-none Composite.

MS. JOHNSON: Just a reminder, I'm sure you guys know this, but since Larry was able to give us, and I couldn't find it in the form, but it was there somewhere, Peg knew where it was, since you know what the two components are, you know that the all-or-none result is going to be less than or equal to the smallest number that was there. So, you don't know what it is, but you know it's going to be something less than or equal to what he's providing. If that helps you any.

CO-CHAIR CASEY: And there would be an opportunity in public comment, as well, to clarify this, right? So, can we vote? Please?

MS. OGUNGBEMI: We are now voting on Performance Gap for Measure 3171. Your options are: 1, High; 2, Moderate; 3, Low; and 4, Insufficient. Voting is open. Results -- we have 16.

Our results are: zero votes High, eight votes Moderate, two votes Low, and six votes Insufficient. Zero percent High, 50

percent Moderate, 13 percent Low, and 38 percent Insufficient, so we land in a grey zone. So, consensus is not reached on Measure 3171 for Performance Gap.

CO-CHAIR CASEY: Thank you. And, again, there will be an opportunity in public comment to help clarify.

MS. MUNTHALI: So, Don, we continue ---

CO-CHAIR CASEY: Yes.

MS. MUNTHALI: -- with the discussion.

CO-CHAIR CASEY: Yes. We won't vote, but we'll continue with the --

MS. MUNTHALI: You do vote. Consensus is not reached, you will hopefully resolve this issue, if this Measure goes forward, during the post-comment call. So, you go to the next Criterion and this is a Composite, so we'll go to 1C. And if we pass that or consensus is not reached, we'll go to the next Criterion, which is Reliability. So, you will go to the next Criterion, which is 1C --

CO-CHAIR CASEY: Okay.

MS. MUNTHALI: -- and you will vote on that.

CO-CHAIR CASEY: So, we'll keep voting. Rich?

MEMBER ANTONELLI: Yes. So, this is the Composite Quality Construct and the rationale. My computer is very slow today, I'm sorry. Okay. The Composite Measures include, we talked about before, the visit to a primary care within 14 days following an ED visit and having at least one fill of a controller med within two months after the ED visit.

I think, Ryan, this is probably the place where you could bring up your observation before. I think this also, from my perspective, does call into question, are we measuring the right things, with respect to how this Measure is constructed? Granted, claims in the primary care setting is relatively easy to measure, so I can understand why that would be in, in this Measure at this point.

I probably feel similarly to this

Measure as I did for 3170 in terms of the rigor, certainly the rigor with which it was put together, but I do think that there are some components that would potentially be missing that I'd like to call out.

So, Ryan, I'm not going to steal your thunder, I'll ask you to bring that up again, but I think first I would like to know, is this a child who or a teenager who has an asthma action plan, as something that would be captured with that connection to the primary care provider. So, I'll throw that out there to stimulate some discussion. And, Barbara, I'll hand it to you next, though.

MEMBER GAGE: Okay. And, again, not being a clinician, but being a researcher, could you identify that care plan through the claims? And we -- either the Measure is inappropriate, because that information is critical, or the other factors in the Composite are equivalent, in terms of identifying that issue. So, I wouldn't downplay the Measure for not having that, because

being able to create it off the claim, I think is valuable.

MEMBER ANTONELLI: Yes. So, I actually agree with that statement as well. That said, and I do want to bring us back, this is a Care Coordination Measure, or at least we're being asked to think about the Care Coordination Measure, and there are codes around care plan development that can be tracked that would not just be the visit code.

CO-CHAIR CASEY: Specifically for asthma?

MEMBER ANTONELLI: I don't think it's specifically for asthma, but there are care coordination codes.

CO-CHAIR CASEY: Right.

MEMBER ANTONELLI: I helped write the language that went to the RUC on that one and we purposefully kept it broad.

CO-CHAIR CASEY: Good. Okay. I think we've got Karen with her card up there.

MEMBER MICHAEL: In my mind, the

issue's not the inclusion of the asthma action plan, because I think administratively that would be hard to gather, even with care coordination codes.

In my mind, the question on the Composite relates to the medication, the need for the medication within the time period after the ER visit. I think that's where this Measure is going to fall out, because you're going to have some members who either the medication really isn't appropriate for or they've got the supply, because they had a three-month fill before.

MEMBER ANTONELLI: Did you want to weigh in, Ryan?

MEMBER COLLER: No, I think you guys both covered --

CO-CHAIR CASEY: Yes, okay.

MEMBER COLLER: -- the same point I had.

CO-CHAIR CASEY: Any other Committee Members? I do think the NHLBI specifies very specific evidence-based elements of a care plan

for childhood asthma pretty clearly. Yes, Barbara?

MEMBER GAGE: While the codes may exist, oftentimes the way codes are reported in the claims are, if they're not important for payment or regulatory purposes, that they may not be present, so you might be undercounting.

CO-CHAIR CASEY: Well, these are now part of payment policy. It's just that they're not specific to asthma, I'm pretty sure of that. So, we won't get into it. Yes, Charissa?

MEMBER PACELLA: So, mine is an ED related comment that I was going to hold for Validity, but since it relates to the other two, what I'm going to say is, there are also, in addition to the presumption that the patient needs medication within those two months, there's also a presumption that if there wasn't a claim for a prescription being filled, that you didn't get it or don't have it.

And many EDs and other places actually have funded programs that are dispensing, have

providers dispensing these medications. We don't let an asthmatic leave our ED without an inhaler in hand and yet, there would be no separate claim for that, necessarily, in a prescription. So, I'm not sure how you would track or even know that.

CO-CHAIR CASEY: Yes. And just let me put in here that, we know that the public comment is on the schedule for 12:30 and we're going to allow that as soon as we finish up here. So, hang in there, we haven't forgotten about you. So, any other questions? Yes, Ellen?

MEMBER SCHULTZ: I would just say that, this discussion around the medication and some of the discussion around what happens at the primary care visit and an asthma action plan makes me wonder that this shouldn't be an either/or Measure.

Looking at the stratification that was provided, at best, the performance would be around 35 percent, I think, if I'm looking at that correctly, which still leaves plenty of room

for improvement.

And so, meeting the numerator by either having a follow-up primary care visit or having a fill for medication, to me, seems like it could balance some of these concerns around cases where good care may have been provided, but it wouldn't be captured by the Measure.

CO-CHAIR CASEY: Thank you. All right. Seeing no upright cards, Yetunde?

MS. OGUNGBEMI: We are now voting on the Composite for Measure 3171. Your options --

DR. KLEINMAN: Is it possible that I could respond to some of those comments? Because I think there's some --

CO-CHAIR CASEY: I think, with all positivity here, we're going to move on, because I think the group has enough information here. We appreciate your presence, but I think, at this point, we want to get through the vote.

DR. KLEINMAN: I appreciate it. There's specific reasons for the 60-day fill that I thought might be helpful.

CO-CHAIR CASEY: That's -- I think we'll postpone that.

MS. OGUNGBEMI: Your options are: 1, High; 2, Moderate; 3, Low; and 4, Insufficient. Voting is open. Results are: zero votes High, six votes Moderate, nine votes Low, and two votes Insufficient. Zero percent High, 35 percent Moderate, 53 percent Low, and 12 percent Insufficient. Measure 3171 does not pass the Composite.

CO-CHAIR CASEY: So, we -- would it be fair, Rich, to expect that, since we're not going to vote further, if we were to get to Reliability, we would have the same sort of type of results as we did, in your estimation?

MEMBER ANTONELLI: Yes.

CO-CHAIR CASEY: So, I think that -- let's just go through the rest of the information that you worked hard on and provide that and have public comment. And then, I think we'll be done. And I think, for the Measure Developer, certainly, any of the things that you want to

highlight will be well served by the public comment period. So, take that as your opportunity.

DR. KLEINMAN: Okay.

MEMBER ANTONELLI: So, the Reliability for 3171, analogous to the conversation we had with 3170, is limited by the lack of data. I appreciate Dr. Kleinman's description and actually, in my view, a rational justification for why there is a gap there.

As the lead discussant, though, I would want to make sure that we can transmit to the Measure Developer and his team that -- bring on the data, because there are elements of this Measure that are attractive. So, I think I'm a bit at a loss to give much more information about the reliability testing, absent the data.

With respect to Validity and validity testing, the -- pulling up my notes here. I think that the discussion that Dr. Kleinman had provided to us was helpful in terms of defining the population.

I think that the discussion about who would fall out of the Measure, that don't have asthma, but may actually present with asthma, is, in my opinion, is spot-on. The -- with respect to exclusions, cystic fibrosis, for example, the ability or the need to risk-adjust was limited and so, therefore, that was fine, in my view.

The -- so, I think, basically, it is -- accepting it as a Composite Measure, with the appropriate data to consider, it is something that we're willing to consider. But I think I basically will end my assessment by saying, let's see more data, with the public comment period coming forward. Barbara, do you want to add anything to this?

MEMBER GAGE: I echo all that and further support the lack of a need for a risk adjustor, because this is kind of -- you would expect, regardless of race, age, sex, et cetera --

MEMBER ANTONELLI: Right.

MEMBER GAGE: -- that this would be

carried out.

MEMBER ANTONELLI: Yes. And then, in terms of the Feasibility, I don't have any concerns about how the Feasibility was discussed in the analysis. The Usability and Use, the -- I can't imagine Measures that identify at-risk sub-populations in pediatrics not looking for a Measure like this to move forward into accountable care.

Being close enough to multiple ACOs around the country formulation, I can -- asthma, asthma, and asthma are probably the three top vote-getters. And so, I think, with the Usability, I think that there is potential with this going forward, once some of our concerns have been addressed.

And then, I think, Don, you had said, talking about harmonization, would be a conversation for later, right? So, we can -- I'll close my comments with that and, Barbara, give you a chance.

MEMBER GAGE: Again, just in terms of

the Usability, even though it's not in use, it seems directly related to preventing adverse events. And so, pretty important.

CO-CHAIR CASEY: So, we have one last task. Elisa wants to get some feedback from the Committee about the vote that did not pass, 1C.

MS. MUNTHALI: Hi. Yes. So, we rarely see votes, Measures go down on 1C, on the Composite Construct. So, we do, for the purpose of our report, want to get a little more understanding from the Committee, a rationale behind your vote. And it sounds like it may be because of the exclusion of that third component, but we just want to make sure.

CO-CHAIR CASEY: Any comments or questions? Do you understand what she's asking for?

MS. MUNTHALI: And --

MEMBER ANTONELLI: Could we put the relevant language here --

MS. MUNTHALI: Yes.

MEMBER ANTONELLI: -- so everybody can

be looking at it, please?

CO-CHAIR CASEY: I'm getting dizzy. Down, 1C.

MEMBER ANTONELLI: And these are the comments. I think it should be a little bit north of that, right?

CO-CHAIR CASEY: North? Okay, you're right. Sorry. There we go.

MEMBER ANTONELLI: There we go.

CO-CHAIR CASEY: Yes.

MEMBER ANTONELLI: Right there. Okay. So, I will start. This is around the Construct of this as a Composite Measure. I think we had -- we received some comments related to the fact of a medication within that window of time.

I think our emergency department colleague from Pittsburgh also called out that medications might have been provided that wouldn't necessarily track into a claims data flow. And then, the Construct itself, about following up with a so-called primary care connection.

That is a claims visit, but I would argue that many medical homes get a list on a daily basis of patients that went to the ED and so, there could be a lot of care coordination that's done telephonically, for example.

Oh, Sally ran out of her inhaler. Well, let me renew that. You don't have to come in and see Dr. Coller today, because she has an asthma action plan and you should have called us, Mrs. Jones, that she needed a refill, but we'll go ahead and make that happen.

So, there are aspects of -- and I think this is why I actually think 3171 is a more reflective measure of care coordination and I think of 3170 as being more a care management. Yes, there's some overlap between the two, I feel that that's absolutely arguable.

But in my view, I think that this really gets at the heart of what good care coordination could do. So, those are my comments, but let's make sure to open up, I want to make sure that I quoted Karen and Ryan and

others correctly.

CO-CHAIR CASEY: Ellen, do you want to?

MEMBER SCHULTZ: I would just say, so, I voted Low on this Criterion, because, to my mind, after the discussion, I feel like it might be better as an either/or.

CO-CHAIR CASEY: Hence, the composite nature of it maybe not being as nice as -- good as you'd like it.

MEMBER SCHULTZ: Well, just, so, in terms of, like, how are the components weighted?

CO-CHAIR CASEY: Right.

MEMBER SCHULTZ: That's what that comes down to.

CO-CHAIR CASEY: Always a problem. Yes. Terry?

MEMBER O'MALLEY: Ditto to that. And I think the components themselves are good, just as a composite, they're too exclusive, hard to meet.

CO-CHAIR CASEY: Very good. Well, you've certainly earned your lunch. Let me just

ask, I don't think we got, Katie, evidence of anyone who wanted to submit public comment. We do have -- do we have anyone in the audience? Is there anyone on the phone that wishes to submit, to give us oral public comment?

OPERATOR: At this time, if you would like to make a comment, please press Star 1.

CO-CHAIR CASEY: So, please press Star 1 on your phone.

OPERATOR: There are no public comments from the phone line.

CO-CHAIR CASEY: Thank you, Operator.

CO-CHAIR LAMB: One of the things we were wondering is, we need to get through the other four Measures, but we also wanted a chance to have everybody weigh in on Gaps and what we're thinking about on a go-forward.

How would you feel about taking about ten minutes or so to get lunch and then, start the Gaps discussion, move into the rest of the Measures, and then, assuming we'll have time at the end, we'll go back to Gaps, but otherwise, we

may not get to Gaps? How would you feel about that? Is that all right with everybody?

CO-CHAIR CASEY: Let me ask a related question. How many of you cannot stay until the 4:00 end time? 5:00, excuse me, I'm on Central Time. Two and a half people? Is that --

CO-CHAIR LAMB: Three, I think there's three.

CO-CHAIR CASEY: Three? So, we still will have a quorum, will we not? And we would hope, if you're on the phone, you could patch in on your way to the airport or something. So, let's break for lunch and then, Gerri, we're going to --

CO-CHAIR LAMB: We're going to move into --

CO-CHAIR CASEY: We're going to move into that and sort of have our lunch and --

CO-CHAIR LAMB: So, come back at about five after and we'll just kind of start the discussion and then move into CDP.

(Whereupon, the above-entitled matter

went off the record at 12:53 p.m. and resumed at 1:08 p.m.)

CO-CHAIR LAMB: So this is kind of a -- it's a beginning salvo into Gaps, and what Don was referring as aspirational, Chris was talking about bridge measures, okay. I think we really got our feet wet into that with the last two measures in terms of where do we want to go from here.

So just a couple of things to get us started, and then we're just going to open it up, because as we shared in the beginning, this standing committee's responsibility is ongoing. We're looking at the portfolio of care coordination in addition to CDP.

So just, you know, in terms of what has been mentioned so far, just to -- and I'm sure the NQF staff have been tracking this, in terms of each of the measures that we have looked at so far in terms of aspiration of the alignment with payment codes, I think the overall theme of these are important measures. We want to kind of

keep up to date with where things are going.

So aligning the measurement codes, the measures with the CPT codes, the whole issue that we just got into with 3170 and 3171 was the composites and what is meaningful in those composites, and we had that whole dialogue of how do we really capture care coordination, and how do we do it in a feasible way when some of the data is available on the EMR and some of it isn't. So all of that is aspirational.

One of the things I've wanted to call out is in our off cycle work, and again these summaries are available for you in the Sharepoint, some of the things that the folks who participated in off cycle recommended as steps for this Committee.

I wanted to throw these you so if you want to reflect on them, you have the chance to do that, was one was that we could keep our eye on the whole portfolio, because one of the issues that we're dealing with is not all the care coordination measures come to us.

They may go to other committees and sometimes we'll be aware of that, sometimes we may not. But one of the things that we proposed during off cycle is that we really keep our arms around the whole portfolio and look at the aspiration. So one thing that Don and I were bouncing around was is this a good year to do an analysis of the whole care coordination portfolio, and you know, what are the strengths, what are we missing and so forth. So we'd be really interested in your thoughts on that, okay.

Another one is to anticipate the needs for the field, and I think we've had a lot of that discussion. So we really are looking at where's the portfolio, what new measures do we need, and how do we really address the evolution of the field, to get back to what Chris is talking about is bridging measures and aspirational measures.

So with that, you know, for the next ten minutes or so let's just kind of have an open-ended discussion of your thoughts on wither

the field, what's missing from what we've seen, and also if you want to comment on the idea of really taking a look at the whole portfolio as a group.

CO-CHAIR CASEY: Let me start by saying thanks to Gerri, and I would also ask that the new members, if you haven't and I don't know if staff is able to locate these, but if you would promise us that you would go to the most recent version of the preferred practices and really look hard at those as a list of ideas, because I think it will help frame set.

You know, I think that if we're just speaking amongst friends here, a lot of what we've seen throughout the course of this standing committee is really provider-centric type measures, many of which are focused on hospitals and EDs. When I think of care coordination, I think of life without those two, right, not that providers aren't important.

I think we tried to make this clear in the preferred practices, but you know, we'd

certainly like to get your perspective, you know. Up here is good, but in the middle of, you know, translating a good idea into something that's tangibly beneficial that we can feed back to measure developers would be useful because, you know, most care coordination takes place outside of those realms, right.

So while I know that that's been our discussion, I think that's been where we've tried to take the world and, you know, as we can see we're still stuck in this traditional environment with measure developers. So that's my two cents.

MEMBER PACELLA: So I was a little disappointed, you know, in looking through the list of measures in terms of care coordination. I see some of the biggest gaps as occurring between very -- in very actionable settings, which would be sort of between emergency departments and chronic care facilities, and emergency departments and people who are already in home care.

So I was really disappointed that the

only ED-based measure, you know, on the list is one focused on discharges. My impression is that the performance gaps and the impact of closing those gaps would be far, far less than the bang for your buck that you would get if you could actually demand, you know, two-way communication in a closed loop around why a patient comes from a care setting to an emergency department, and then on the back end why a patient goes from an emergency department back to their setting and what their additional needs might or might not be.

CO-CHAIR CASEY: Charissa, could I -- can I modify your idea by suggesting it be three-way, potentially with patients and caregivers as the third leg?

MEMBER PACELLA: Absolutely.

MEMBER O'MALLEY: Yeah. I'm glad that was brought up Don, thanks, because I think we need some patient-centered outcomes, and I will introduce my compatriot next door who has actually developed a measure published on it, and

it's called Care Integration. It's just a different slice through care coordination from the perception of in this case the family and the child.

So (a), I would put that forward as one and we're just going to keep going as well, to two other things. The extension of care coordination has to go across the entire continuum of care, as we alluded. It's got to include both acute care sites and even, and more importantly, into the home-based care models, the community-based service providers.

One of the difficulties in that, one of the many difficulties in building measures that can extend across the continuum is that there's no shared information platform across the continuum. So we're going to be going back to the facts found in paper. It's not going to be electronic, at least not for many years, for a variety of reasons. So just to make sure that that's in place.

But perhaps the only unifying piece

across the continuum is the individual themselves and their experience of coordinating care. So I think if we don't lose sight of that, we'll be in good stead. So --

CO-CHAIR LAMB: Brenda.

MEMBER LEATH: Thank you, and what I would like to suggest is that we consider community-based care coordination, which incorporates not only the movement between health care organizations but Health and Human Service organizations, and on top of that I'd like to add, just based on the work that I'm involved in, taking a look at coordination among organizations that perform care coordination services. So that's what I would like to contribute.

CO-CHAIR LAMB: Ellen.

MEMBER SCHULTZ: Yeah. I want to really echo what both Terry and Brenda said. On the one hand I think there's going to be a recognition that we need to make the tent bigger. It's not just about connecting the dots of what's traditionally been sort of the medical care

system, but we need to connect up with community services and, you know, things like dental, things like behavioral health.

I mean there's a huge division there that needs to be bridged, where there's a lot of demand for care coordination. To Terry's point, you know, right now with all the fragmentation in our system and the way that we document care coordination, it's the patient or their immediate caregivers who help coordinate their care. They're the one thing that connects all those dots.

I've spent the last 15 months on a separate project trying to reimagine what does health care measurement look like if we see it through a patient-centered lens? This goes way beyond just care coordination, but you know, that to me is a really big missing piece. Like we're not hearing enough from patients and caregivers directly, and I think that's a voice that we would do well to bring into the conversation.

That might really change how we see

things, and particularly anything that this Committee does or the NQF does to think about, you know, calling out gaps and pushing the envelope, trying to be really aspirational. If we don't include that patient and family-centered perspective, like why are we bothering?

MEMBER HOHL: This is Dawn. I would 100 percent echo what you said, because I was thinking when someone else had made a mention. I know we've started like a patient family advisory group a couple of years, and I'll tell you it has really revolutionized our thinking on many things we're doing. I think that was a great idea. I think we get insights.

CO-CHAIR LAMB: Thanks.

MEMBER DEZII: Yeah, I've been working with the National Health Council trying to develop initiatives and support the activation and engagement of patients. You know, you hear the patient voice, the patient voice and you know why they say stuff and nothing sticks. Also, also you know, involving patients in decisions

and shared decisions is not passing all of the decision to them, because patients are ill equipped.

There's a long way to go in energizing them and they need to be part of the -- they need to be here in a way. There's a lot of the things they can't comment on. But you know, that has to be in mind. Terry just made me go back 30 years to paper and faxes and what's going on with this machine. It's been out of paper for like a week.

I wonder if a step up, a step up is email and PDFs, you know. I know that carries its own kind of thing. And also I'm thinking, you know it's -- we get the measures that the measures developers present to us. So there has to be a way or there should be a way to get them to focus. Further downstream, like Charissa mentioned, you know, the linkages with the external community, you know.

Maybe the measures should be rather than her do something and ship somebody out is

wherever somebody is to be able to get shipped to won't accept what they get until they get what they need. It's just a different, it's just a different perspective. You know, for example all hospitals value an ER person.

I mean, you know, you'll get some action at some facilities. We will not accept this patient until, you know, we have what we need. I mean that will happen once right, and then it won't happen again. I'm sorry. It was a little long-winded and but that's --

CO-CHAIR LAMB: That's okay. Samira?

MEMBER BECKWITH: I think is a very appropriate conversation to have, and I guess I would just say from myself very heartwarming, because I started in the 70's with hospice care and wanting care to be different for people than it was in the traditional health care system. So I feel like I've waited 35-40 years for this conversation, and to be a part of it is really very heartwarming for me.

I would just agree with what everybody

has said. It's not just one component of care that's going to make it possible. We have to think about the future of our country and the entire health care system, and you know, having my roots in hospice care now branching out and providing PACE and all these additional programs, trying to cobble it together in a way to provide the care that people need in the system that doesn't pay the way that really pays for coordinated care.

I think this is the beginning of moving the system forward, so I find this all very exciting.

CO-CHAIR LAMB: Shari.

MEMBER ERICKSON: So I just want to echo again I think what Ellen said down there. I mean that has -- the patient really, looking at it from that perspective, has to be the guiding light so to speak for moving performance measurement forward.

I think there's absolutely no question of that, and we're not -- it's just if we don't

start to do that and think about how to do that, and I think NQF can have a role in trying to help all the different stakeholders around the table figure out how to do that.

I think that would be absolutely, you know, getting outside of, you know, and the CDP is critically important. It needs to continue, but getting outside of that box and thinking out of that box to help the movement move forward. The other thing I would say, you know, is what I hear a lot from those that are -- and members of ACP that are really actively engaged in implementing measures in their systems, who care a lot about them, who understand the importance of measurement, that even measures that they find that NQF has endorsed that the MAP has recommended, that you know are being used, that are clinically relevant, valid, all of these things, when you implement them there are things that happen in a system that are unexpected in terms of how the data are collected, in terms of how the, you know, the way --

And it can be variable across systems, but and that can vary and unexpected burdens on those that are trying to do the right thing. To the extent that NQF could help, you know, look at that and really this fits in use and usability, you know. How can we better understand, I guess it's post-market surveillance? How can we understand what those issues are, and you can get -- I can get tons of use pieces. I can collect them all day long from members saying this is the problem with this and maybe they're just doing it wrong? It may be.

But you know, when it's in a large system or something like that, you know, it gets integrated. And so, you know, to the extent that that feedback can come in and help influence the process, I think that would be -- that would be so meaningful to those on the ground who really want to do the right thing at the right time for the right patients, but just -- it just gets in the way.

CO-CHAIR LAMB: And I would just add

to Shari that we're also a voice for that. We only have about five minutes more before we move into CDP. Let me just turn to the phone. Lorna or Marcia, do you have anything that you would like to share related to Gaps. Hopefully we'll have time at the end. If we don't, this discussion will continue. But it's just good to have it face to face. Lorna, any comments you want to make or talk to us?

(No response.)

CO-CHAIR LAMB: Okay, Marcia?

MEMBER JAMES: Hi. No, I'm just listening and I wish I could be there. But I'm in an airport getting ready to get on a flight, so I'm listening in on the conversation, though. I don't have anything else to add, thanks.

CO-CHAIR CASEY: Gerri, I just wanted to dovetail with what Shari said, by reminding you that you might have seen a piece in the New York Times probably a couple of years ago, which was loosely writ. The challenges of coordinating the care coordinators, you know, which is also a

problem.

There's a metal level where you've got so many people coming at you trying to be helpful. But it really is a big challenge, I think.

CO-CHAIR LAMB: I'm going to ask those of you who have your names up, if you could limit, just so we get the ideas out and hopefully we'll get back to it. But limit your comment to what's most important and you've got a minute. I'm going to do Don here again. So Chris, you've got a minute. Okay, you're going to turn it over. Who are you giving it over to, Rich?

MEMBER ANTONELLI: And I can do this in 60 seconds. So first of all I want to voice my enthusiastic support for the suggestion that you made about doing a measure review, and Don, I think the ability to cross-walk on an hierarchical basis to the preferred practices, it's elegant. We need it like yesterday.

In '09, the Commonwealth Fund asked us to do a policy brief, and we actually said care

coordination is a set of activities and processes. I think one of the things that I struggle with inside this Committee is that's why we see some of these measures of, you know, did a fax a piece of paper, etcetera.

So we, in our work in Boston and some of the places that we're consulting with actually globally now is looking at person-centered care. So to the degree that the NQF or those of us that are key stakeholders would want to use language that seems like it's going to be getting increasingly universally accepted, to be focusing on the outcome of integration.

And then what happens in the realm of activities, tools and processes of care coordination, those become intermediary measures. And so I wish that I could control the name of this Committee, because to the degree that we're thinking about outcomes, this should be the standing committee on care integration, and that we would then look at does this map to activities, small M map, does this map to

activities that we could measure in an EMR, in an EHR.

But the outcome is actually the person, family caregiver unit. So I struggle with this concept. I think the field has moved actually thinking about care coordination as tactics, and the strategy is integration. That, Brenda, is how we bring in those community-based organizations. That's the only line of sight I have strategically in building a Medicaid ACO for children, for mitigating social determinants of health.

For some reason I can't talk my neurosurgeons into ameliorating poverty. Imagine that. But this is how you build community linkages. Thank you.

CO-CHAIR LAMB: Thanks. Okay Emma, one minute.

MEMBER KOPLEFF: Okay, a tough act to follow. No, thank you, Rich. I just wanted to ask that our report for this Committee reflect two different kinds of gaps, which I think have

been addressed. But one is a lot of this discussion right now has been about the big picture concepts, and I'm not going to repeat what Rich said, but he so eloquently put together this framework for how potentially this group could move forward the field of concepts like patient-centeredness.

But I think there's a lot of detailed work and detailed discussion to be had that we're not going to have the chance to have in one meeting. So A, the recommendation should do more of that in off cycle or whenever that may be.

Two, I just want to make sure that some of the gaps identified as they relate to our bridge-building measures as we've called them today, so the measures we've already reviewed or perhaps that we're about to review, where we recognize this measure is getting us here, but where we really want to go is here.

There's some specifics there that we've hopefully had our developers here, but not all of them were mentioned. For example, with

advance care plans, we talked about the concept of one care plan. I don't think we've mentioned the concept of extending the denominator to a population beyond just those 65 and older.

Some of those sort of specific nuggets that take the measures as they exist now and perhaps all that we can achieve now, and gradually sort of see them on a path forward, to get us to some of these -- to where we want to go. So thanks.

CO-CHAIR LAMB: Thanks Emma. Jeff.

MEMBER WIEFERICH: I can't be quiet without putting a plug in for behavioral health. I want to thank Ellen for being the first to bring it up, having the connection with behavioral health and also Brenda talked about the community workers. Those are two critical areas in specialty in terms of what I've seen in terms of the care people need.

So we need to be sure we include those components if we're going to be looking at the entire picture and the entire individual.

DR. WILSON: Sure. Hi, my name is Marcia Wilson. I'm senior vice president here at National Quality Forum. This has been a great discussion. I know it will continue later on today. But I wanted to let you know about three projects here at NQF that are very much related to your work, and it's one of the reasons that I'm in the room and several of my colleagues are in the room.

First of all, National Health Council has a grant from PCORI to develop a quality curriculum, a curriculum about what is quality, why do we care about performance measures that their associations can use. And you know their associations are patients and caregivers.

We are part of that grant, so we sit in with them. We share resources with them. So that's a first thing. The second thing is I only have a minute, so I should talk very fast. We have a project funded by the Centers for Medicare and Medicaid Services on emergency department transitions of care.

So we are specifically looking at that patient that comes into the emergency room and goes back out to the emergency room. They could come from anywhere, they could go anywhere. What makes for a quality transition of care? How are we measuring that? And actually Terry O'Malley was gracious enough to be a key informant along with our expert panel to give us more information, so we really appreciate his work.

And then the third thing I would say is one of our strategic initiatives here at National Quality Forum is feedback on measures, and I think I've just heard that comment, which is we're going to be working with some of our member organizations, and we would work with organizations who are not members to get enhanced expanded feedback on measures.

When measures come back for maintenance and review, you want to know what happened to the measures when they went out in the field? What were the implementation issues? Did behavior change? Did processes change? What

was the good, the bad and the ugly about those measures?

So we are actually having a group tomorrow that's going to be chatting with us about how this initiative will roll out. We have a couple of member organizations who said we would like to work with you and reach out to our members that give you feedback on measures.

So more to come on that, stay tuned. But thank you all very much for your discussion. I just wanted to try and connect the dots with some of the other NQF work. I think that was a minute and a half.

CO-CHAIR LAMB: That's great, Marcia. We're going to move back into CDP. Hopefully, we will have a chance, one minute. Oh you're done?

(Off mic comment.)

CO-CHAIR LAMB: Okay.

MEMBER DEZII: It's related to what Richard said, so I remembered what I wanted to say. Perhaps another domain, and it would be even beyond this but frankly linkage to the

continuum, linkage to the continuum. How the measure is linked to the continuum to have folks think about where, you know, that stuff.

It would be nice to be able to read stuff from these measures that speaks to that. That's it.

CO-CHAIR LAMB: Thank you, Chris. Just a couple of things. We will come back to this hopefully. This will be a continuing dialogue in addition to our CDP work. I would just also, as Don has already encouraged you, take a look at the preferred practices, because I think it speaks to several of the gap areas that we've just mentioned.

The other is to take a look at the measure domains from 2014, because it may be a place that we want to go back to in terms of some of the core constructs that you've just mentioned. If you look at the core domains, okay, person-centered, plan of care, health care neighborhood, which is a much broader continuum construct, and then the outcomes from the person

-- person's point of view.

Those are already in the framework. What we're talking about here is how do we get, as several of you have said, from here to the aspirational framework. So please keep those in mind when we come back to it. This is a very rich and as Samira is saying very important discussion.

CO-CHAIR CASEY: Gerri, let me just say that the other thing here is care coordination happens and so what, right? What's the impact, right? We've got to finish that sentence.

CO-CHAIR LAMB: That's great. It took ten seconds. It's very true. We're doing outcomes, and that's going to be an absolute critical piece. Okay. So I think you've all said it is taking our CDP in context of where are we now, evaluating them where we are now, okay, and then aspirationally becomes our gap discussion.

Okay. We're now on to 646, and our

measure developers are with us, and so 646, Reconciled Med List Received by Discharged Patients. Chris, are you up first? Okay. Oh, excuse me. I'm sorry. The measure developers get their five minutes of fame here. Sorry.

MS. CHAVARRIA: Thank you so much. I work from the PCPI and my colleagues and I are happy to be here and to present our measures, and thank you for your time in reviewing them. So the PCPI measures are developed by multi-disciplinary and multi-specialty expert work groups. The PCPI expert work groups do develop these measures based on clinical guideline recommendations, supporting by high level evidence.

However, in some instances, performance measures do not lend themselves to rigorous studies including randomized control trials, and I think that's the case with these measures certainly. There are studies and systematic reviews -- including two recent ones that I have here with me -- on medication

reconciliation interventions, including pharmacist-related hospital staff education and IT-focused interventions.

However, these interventions are beyond the scope of this measure, as this measure does not include elements related to pharmacy or pharmacist-based interventions or IT-based interventions. They're very broad measures, hopefully for the implementation in a broad variety of facilities.

They are different than many of our other measures in that we tend to develop measures for physical level reporting and accountability programs, and usually with those measures we bring back PQRS data or other types of data that will hopefully show a progression, a positive progression on the performance on these measures.

However, these being facility-based measures, as you all noted in the comments and during our previous call about two weeks ago, we do not have a robust implementation for these

measures yet. And, as Marcia was mentioning, we do try to bring -- for maintenance of measures, we do try to bring data showing the progression of these measures and the performance, and hopefully that it's changed.

That is not the case with these measures. Some of them have been picked up in programs. However, we do not yet have the data for those. The expert work group felt that these measures that are before you today, all four of them, the next ones that we'll discuss, represent a fundamental step in improving elements of care transitions, and we certainly heard the standing committee during the initial care and within your comments that you provided, about the limitations of these measures including, as I mentioned, the evidence base.

But we do have a process whereby our expert work groups can address these as part of the iterative measure maintenance and update process. So that's something that we're certainly here to listen to your additional

concerns about these measures, and then see.

As they stand right now, we have them, but certainly at a later point maybe get together regardless of what happens here with the endorsement of these measures, get together with our expert work group and try to improve upon these measures because bottom line, we want to make sure that care transitions are improved and patients have the information they need.

So for Measure 647, one of the concerns was also that we didn't have sufficient gap data or updated gap data. So I was able to find gap data for many of these measures, and I'll present them for each measure during the gap discussion.

So this first measure, Reconciled Medication List Received by Discharged Patients. Basically it assesses the discharges from an inpatient facility, and that patients or their caregivers received a reconciled medication list at time of discharge, including medications to be taken or medications not to be taken by their

patient --

CO-CHAIR LAMB: Can I ask you to hold the extra data --

MS. CHAVARRIA: Yes.

CO-CHAIR LAMB: --- until we get to that specific review, and then we can ask you to share that with us?

MS. CHAVARRIA: Absolutely, absolutely.

CO-CHAIR LAMB: That way we'll go through kind of a standard review.

MS. CHAVARRIA: Okay. So I'll just provide a quick rationale, and then the exclusions are patients who died and patients who left against medical advice, which was one of the concerns as well.

(Off-mic comment.)

CO-CHAIR LAMB: Okay. Just to draw to your attention -- there we go. PCPI measure developers did share additional reliability data with us after the call. You all should have gotten that. No? Okay. So that will be part of

this review. So we're going to move into the review then of 646. Chris, you're taking lead?

MEMBER DEZII: Yes ma'am.

CO-CHAIR LAMB: If you would start us off?

MEMBER DEZII: Right. Thank you. I'll follow my script here. This is 646, the measure number. The title is Reconciled Medication list Received by Discharged Patients. Discharge is from an inpatient facility to home, self care or any other site of care. It's a reconciled list to the patients, not the facilities.

The description is the percentage of discharges from an inpatient facility, hospital or inpatient or observation, skilled nursing facility or rehab facility.

It's a home for any other site of care in which the patient, regardless of age or their caregiver, received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories. The

level of analysis is facility and integrated delivery systems.

Getting to the evidence, this is an NQF-endorsed measure undergoing maintenance evaluation. It is a process measure. The evidence, the evidence is a bit dated in my opinion. It's from, however, still important and relevant. It's from a 2006 Transitions of Care Consensus Conference. It's essentially a standard of care conference by the American College of Physicians, the Society of General Internal Medicine and the Society of Hospital Medicine, that had an output from the consensus conference with a set of eight standards.

One of those standards is a reconciled medication list. So you know, I'll call that a standard of -- well, I'll call that a standard of care. They propose the minimal set of data elements that should always be part of the transition record, such as principle diagnosis and problem list, medication list, test results, pending results, medication reconciliation,

standard of care, a performance metric constructed to facilitate, enable -- to enable the standard as useful.

Now the evidence is based on the NQF's measure maintenance policy. This evidence is considered a pass. If the Committee agrees the evidence basis for the measure has not changed -- and the measure developer tells me that the evidence really hasn't changed, right? There isn't anything more. There may not be a need for a repeat discussion and vote on the evidence.

Now we probably -- I don't know if we're going to vote on this, but we should probably talk about it, because this is the evidence base for all the other measures too, okay? So now the comments I got from my colleagues, and I must -- I guess I have to admit that I had some technical difficulties and I have my whole opinions here without seeing what the rest of my committee had to say or the group that I'm with.

But, you know, pretty much identify

that the evidence is weak, insufficient. However, I mean and in its present state, it does rise to the level of pass for the NQF. It's part of me, part of me wonders why there has been no movement in evidence development since 2006. What is it, 2017 right? I mean, okay. Sorry. I'm getting old.

You know, and that's part of the gap that I didn't get to say, but I guess since I have the floor, I'll take it. I mean the paucity of evidence that comes out of the measure space to date is pretty remarkable I think. All right. I don't mean -- I sound like I'm beating up on the measure and I'm not. Maybe I am. Do you have any comments about what I just said about the evidence for this measure?

MS. CHAVARRIA: So it is. It is an issue because again, these are broad measures, and this is what the expert work group thought was a gap in care that needed to be addressed. We do have consensus policy statements from 2009, the TOCCC.

MEMBER DEZII: Yeah.

MS. CHAVARRIA: And unfortunately in some of the reviews, the systematic reviews that I do have, they're always calling for improved or more robust studies around this, this area. So it really is an issue that needs to be studied more, and there is a paucity of data at this point.

MEMBER DEZII: Yeah, yeah. Now I agree. I mean empirically we all know that this is an issue, and this is where I started my concept of the bridge, you know. This measure is necessary to be able to, you know. The next measure you developed. Do you develop primarily measures or just do maintenance measures?

MS. CHAVARRIA: No. We haven't developed new ones, but that's part of our work plan.

MEMBER DEZII: Okay, okay. This measure matters when we know the impact of what it is we've done with this measure, as well as the other measures. So you know, I hope that

we're not still referring to the 2006 Transitions of Care evidence three years from now. All right. Oh, I sound like a hard guy.

CO-CHAIR LAMB: Chris, so to summarize then, basically the evidence has not changed. We'd like to see evidence down the road.

MEMBER DEZII: Correct.

CO-CHAIR LAMB: Let me just open it up. I don't think your two co-reviewers are here. Marcia, I think, was taking a plane and I'm not sure if Colby ever got on. No? Okay. So I guess Chris make a recommendation, because the evidence has not changed. As you were saying, we don't necessarily have to review that or vote on it again. Do you have a recommendation?

MEMBER DEZII: I have a recommendation that we -- now when we're talking our evidence, is performance gap a different discussion? Okay. I move that we -- I see no need to further -- I was going to beat this dead horse, but discuss this evidence right now, and move that we move

on.

CO-CHAIR LAMB: Let's open that up for discussion, so that Chris is recommending that we just move forward, that we do not vote on it and the evidence is what it is right now. Comments? Ellen.

MEMBER SCHULTZ: I would second that. I mean I've spent a lot of time digging through care coordination literature and there are more gaps there even perhaps than around measurement. So I think at least having strong expert recommendations is something as a basis, and I wouldn't expect that the importance of medication reconciliation has changed dramatically in the last decade.

CO-CHAIR LAMB: Rich.

MEMBER ANTONELLI: So I am struck by how long this has been fielded and effective. There's no new evidence, and then there's a parallel huge body of work, and that is meaningful use that included med reconciliation. I, you know, want to just ask, you know, can we

learn anything? Is there anything that came out of the meaningful use experience that even could potentially cross over into this to provide evidence, because I --

You know, I'm looking at two separate processes, and is there an inkling of something positive that's come out of either of them?

MS. CHAVARRIA: Unfortunately, I'm not sure. We'd have to do some digging and to find whether the parallels are close enough to be able to make some decisions or some consideration on that, but do you guys have anything else?

MS. GRAY: Yeah. I think that's a great suggestion, to look at the medication reconciliation measure within meaningful use. When we request data from CMS for meaningful use and PQRS MIPS, we generally only request data for the measures that we steward.

So I'm not sure if we would be able to get that data. If we can, I think it would be, you know, really helpful and valuable to perform an analysis of that data and try and, you know,

apply that because it is related.

MEMBER ANTONELLI: Just a follow-on, and maybe this gets parking lotted when we get to the piece about harmonization. But this one for me is aching for a conversation about, you know, parsimony and harmonization. How does this relate to meaningful use? Do we need this measure? Is it better because it's patient directed versus EHR-based?

But so those are the two points that I would raise about this, the first one relating to the paucity of evidence, even after this many years.

CO-CHAIR CASEY: Yeah. So I -- I don't know if you can see the screen, but I -- and I was sorry I wasn't on this call. But I found two systematic reviews. It wasn't clear from the documentation whether what you were referencing that's now over ten years old was even based upon an explicit evaluation of evidence.

I was dismayed as a PCI member to see

that you didn't have those two references, one from Archives which is cited here, which shows that there's a paucity of rigorously designed studies comparing -- this is inpatient now, inpatient med rec practices on outcomes, right.

And there are no high quality studies. This other one was just published last year in BMC Medical Informatics and Decision-Making, again showing the same types of things, you know, that it minimized unintended discrepancies but it couldn't link it to any outcomes of safety or harm or anything.

So while I like the idea of med rec, I mean I go to my own doctors and I have to tell you, even in one Epic system, I've never seen my providers get my meds right once. So I'm just saying that I have a lot of skepticism, so I'll just leave it at that.

MS. CHAVARRIA: I do have two systematic reviews from the -- they're from 2013, and I think it's the one that you mentioned, and what they've looked were studies again that were

-- we are talking about a measure where the medication reconciliation documentation was provided to the patient, and the patient then can take that information and make sure that they adhere to it.

These were studies done, whether pharmacy-related, IT-related. There were others with follow-up about five days after the discharge, follow-up from staff at the hospital. So these were kind of different types of interventions, and whether that in fact improved outcomes with a patient.

But it did not speak specifically about providing the education necessarily, just in med rec listing to the patients. So these are beyond with elements -- let's say we developed one where our pharmacy transitioned records or medication reconciliation lists better than others. But certainly we would be able to use this and provide this type of information.

CO-CHAIR CASEY: Well if I may, you know, and again I'm a proponent of this measure,

but what is missing you mentioned education, which is not just here's your list, right? It's what is this for, what good does it do me, is there a cheaper drug I can take, right? And I don't think any of these questions get asked in this.

Plus it's like here's your list, see you later. That's what happens in practice, right?

MS. CHAVARRIA: Yeah.

CO-CHAIR CASEY: I know, because I've got sheets of these things at home. So I'm -- as you can tell, I'm pretty emotional about this. But you mentioned education, and I don't see that here.

MS. CHAVARRIA: No absolutely, and this --

CO-CHAIR CASEY: So I'm just -- this is probably more feedback for the future, but you're way short of where you need to be on this.

MS. CHAVARRIA: Yes. I think you might be talking about --

CO-CHAIR CASEY: Sounds like on C-SPAN interviewing Trump candidates, you know, but whatever.

MS. CHAVARRIA: Like a patient reported outcome measure perhaps at some point. But again, this is not where we are with this measure at this point.

MEMBER DEZII: That's why I articulated the word "reconciled." I mean there's, you know, it's -- the measure is the delivery of a reconciled list, you know. It's like that old thing, you know. You put something here, a miracle occurs and then you have something here. The reconciliation process really is not -- it's not discussed or mentioned here.

CO-CHAIR LAMB: Rich.

MEMBER ANTONELLI: So Chris, can I politely challenge you to justify why we shouldn't vote on the evidence for this measure at this point?

MEMBER DEZII: Well, the reason I

suggested that is because as it's constructed, it does and NQF has new evidence-based hurdles, is that it passed their hurdle. That's --

MEMBER ANTONELLI: But this Committee has to serve its function, which doesn't necessarily mean that whatever the staff says we have to go along with. So I guess I'm just -- and by the way, there's a cardiac surgeon in Boston that says I have no dog in this fight, and I don't have a dog in this fight although I hate that expression.

But I am concerned with the sentiment that I'm hearing, that we should just jump over and not vote or at least have a little bit more vigorous debate about justifying why we wouldn't vote. I'm sensing a lot of dystonia here.

MEMBER DEZII: Agreed.

CO-CHAIR LAMB: Elisa.

MS. MUNTHALI: So you are right. I think Chris said it. You do not have to take our recommendations. They're just our preliminary look at the submission as staff sees it, just a

recommendation. However, while this measure did pass evidence, was it 2008 when it was first brought forward or -- it was a while ago, we have since changed, you know, our evidence rating.

I hear there's quite a bit of struggle. It doesn't sound like there is consensus on where you want to go. A staff recommendation from me would be for you to vote on it. One of the concerns you have is about the insufficient evidence. We do have a pathway, recognizing that some measures may not have systematic reviews or the body of evidence that other measures may have.

So if you do vote for an exception to the evidence, insufficient evidence with an exception, that is a pathway. It will go forward through the evidence criteria and go to performance gap and all the rest. It wouldn't fail, but you must vote -- if you do that insufficient, a low vote would fail this measure. So I hope that makes it clear.

We didn't have that before when this

measure came forward to you, so that's why it doesn't say previous vote insufficient with exception.

CO-CHAIR LAMB: Elisa, may I ask, because I was going to recommend we take a vote. I think there's enough question in the room. Is "with exception" one of our options?

MS. MUNTHALI: So you'd have to go through insufficient. So Yetunde, perhaps you can pull up the algorithm first and I think everyone has a copy at your desk, and this would be the evidence algorithm. It's the first one you see.

CO-CHAIR LAMB: I should pull it up too. I actually can't see anything over there so -- it's a little small.

MS. MUNTHALI: So we would walk down the first boxes, the green box as a measure, assess the performance on health outcome. It's now obviously this is a process measure. The blue, we'd follow the algorithm down to three. We'd go to the seven, which is the purple. Is

empirical evidence submitted but without systematic review and grading of the evidence, and it's no.

So then we go to the next page, and this is where we land. Are there or should there be performance measures of a related health outcome or evidence-based intermediate clinical outcome or process? If you voted no, then you'd go to your right to Box 11. Is there evidence of a systematic assessment of expert opinion, that the benefits of what is being measured outweigh potential harms.

If that is yes, then you go to the next box, which is 12, and does the steering committee here, and this is a standing committee, agree that it is okay or beneficial to hold providers accountable for performance in the absence of empirical evidence of benefit to patients, and there's some considerations that are in the -- that are listed there, and if you said yes, then we would rate it as insufficient evidence with exception.

Just wanted to walk you through how you would land at that decision point. So Yetunde, if you pulled up the voting slides, what it would give you is a rating of 1 high, 2 moderate, 3 low and 4 would be insufficient. You would have to vote insufficient.

Then we'd take you to another slide that says do you agree that the benefit -- it's okay to hold providers accountable for performance in the absence of empirical evidence. So that would be the insufficient evidence with exception.

So there are two different slides, but you have to land on insufficient. A low would fail the measure. So I just wanted to clarify that.

CO-CHAIR LAMB: Does anybody have questions about that before we vote? Don.

CO-CHAIR CASEY: Elisa, I just want to be certain I understand the specifics here. The measure developers submitted their measure specs with the evidence, and we enhanced that. So are

you talking about this in the context of just what the measure developers have done, or does it include what we've been able to identify, even though it's not part of the measure submission?

MS. MUNTHALI: So what they submitted, did you just submit it now? If you're considering it now, you wanted to update your submission with this additional evidence. Then the Committee would have to decide whether or not that's sufficient.

The additional information that you've brought forward, that is -- it's good context, and perhaps that's something you can look for, and during the post-comment call make sure you have that information updated in your submission.

So it would be -- if it didn't go forward and people really felt that there is evidence out there; however, your submission does not contain that information, the Committee would probably vote low and the measure would fail.

But you can come back during the commenting period with this additional evidence.

I hope that clears it up.

CO-CHAIR LAMB: Is everybody ready to vote? Terry?

MEMBER O'MALLEY: Just a clarification. So if we were to vote insufficient, and sufficient numbers of us voted that way, we would pass -- we would move this beyond evidence to the next consideration.

MS. MUNTHALI: Then you would have to decide whether or not you would want to invoke the insufficient with exception.

MEMBER O'MALLEY: Right, so and then we'd have to invoke that and then move to the next slide.

MS. MUNTHALI: Yeah, then you move to the next.

MEMBER O'MALLEY: If we voted anything else that didn't get it to pass, then it would fail the evidence and fail as a measure?

MS. MUNTHALI: Yes. So essentially it's low, majority voting low.

MEMBER O'MALLEY: Yeah, okay. So the

choice is vote low and the measure doesn't go forward, or vote insufficient and then we get to decide whether that's sufficient?

MS. MUNTHALI: I mean it's -- what's complicating it is we have additional information that was brought forward to you today. It is not part of the submission that you reviewed, but we recognize it's there. There's still an opportunity for the developers to work on the measure, update the measure with the additional evidence and bring it forward to you for a final decision.

CO-CHAIR LAMB: Elisa, I have to ask a question then. Just so that if we -- I understand if we all vote insufficient, that can they then bring it back or it ends it right there?

MS. MUNTHALI: No. If you vote insufficient, then we would ask you the question of whether or not you want to invoke the exception.

(Off-mic comment.)

MS. MUNTHALI: If you don't, then it dies there and they can come back with the additional --

(Off-mic comment.)

CO-CHAIR LAMB: Is everybody perfectly clear on that? Okay.

MEMBER ANTONELLI: You were just shutting your microphone off. Did you say that it can come back? Okay, thank you.

MS. MUNTHALI: Yes.

CO-CHAIR LAMB: Okay.

MEMBER HOHL: Oh, I'm sorry. Could you just review again the difference if we vote low?

MS. MUNTHALI: So if you vote low, you're saying that the quality of the evidence there is, it's low. It's not good quality. If you're saying insufficient, you're saying that you know that there is additional evidence out there or there's evidence out there that probably hasn't been included in the submission.

So you would then say well -- or you

might be saying that there's not enough evidence in this area. So it gets you to two different decision points. It can potentially get you to two different decision points. Low would definitely kill it right now. Insufficient may give you an opportunity for the measure to survive today.

But it can come back also once you have considered the Committee's recommendations and also the additional studies that they've presented to you today.

MEMBER HOHL: Okay, thank you.

CO-CHAIR LAMB: Ready? Any other questions? Okay. Yetunde.

MS. OGUNGBEMI: We are now voting on the evidence for Measure 0646, Reconciled Medication List Received by Discharged Patients. Your options are 1 high, 2 moderate, 3 low and 4 insufficient. Voting is open.

[VOTING.]

MS. OGUNGBEMI: Results are 0 votes high and moderate, 1 vote low and 15 votes

insufficient. 0 percent high, 0 percent moderate, 6 percent low and 94 percent insufficient. So we will move on to voting on the empirical evidence with exception, or if you want to vote on that.

(Pause.)

MS. OGUNGBEMI: So we are now voting on the potential exception to empirical evidence for Measure 0646. Your options are 1 insufficient evidence with exception and 2, no exception.

CO-CHAIR LAMB: Before we vote, don't vote yet please. I just want to be clear on this. If we do no exception, it still can come back?

MS. MUNTHALI: Yes.

CO-CHAIR LAMB: And if we do insufficient with exception, we just move on?

MS. MUNTHALI: Yes.

CO-CHAIR LAMB: Okay. So the difference is timing, is that correct?

MS. MUNTHALI: It's timing.

CO-CHAIR LAMB: Okay. So if we move insufficient evidence with exception, we're going to go through the rest of the review now. If we say no exception, then the measure developer, PCPI, can bring it back to us, and then we would go through the rest of the review. Did I get that correct?

MS. MUNTHALI: Yes. So it would essentially fail if you said no exception.

MS. OGUNGBEMI: Voting is open. If you press something that you did not mean to press, just press another button.

[VOTING.]

FEMALE PARTICIPANT: Can you review again the options there?

MS. OGUNGBEMI: Yes. 1 is insufficient evidence with exception and 2 is no exception.

[VOTING.]

MS. OGUNGBEMI: Results are 13 votes insufficient evidence with exception and 3 votes no exception, 81 percent insufficient and 19

percent no exception. So we will move on to performance gap.

CO-CHAIR LAMB: Thank you everybody. Very thoughtful discussion. I think we will probably have similar ones on the other three measures, so hopefully we all understand the options now. Okay, so Chris.

MEMBER DEZII: Good input everyone. We'll have as much fun here in the performance gap, because frankly there is no information on performance. It's the evidence is -- well, there's no information provided. There's no new data, and I think you were very -- you indicated there really aren't any performance scores here. So performance gap is insufficient. I can go on and on and on, but I won't, unless the developer can fill a gap there.

MS. CHAVARRIA: Yes, I do.

MEMBER DEZII: What's your name?

MS. CHAVARRIA: It's Elvia.

MEMBER DEZII: Elvie, I'm sorry.

MS. CHAVARRIA: No problem, no

problem. So while we did provide some information you -- and it's from the CDC, in that they did provide quite a bit of information -- and we did provide it in the submission -- that adverse drug events result in 700,000 emergency department visits and 120,000 hospitalizations each year.

So then there's a gap in terms of the results of not providing maybe some information, or maybe other things too, but at least certainly somewhat related. Now the issue here is that the CDC also, as you see in your information that you have before you, that the CDC does expect these numbers to increase, due to not only the polypharmacy that we have -- are seeing now and increasingly aging American population and development of new medications.

So what I did is to try to really get at the issue and not provide gaps that maybe are not directly related to what we're trying to measure, which is I think where the issue lies. But we do have some additional information, and

that's from the Wong article. We did provide that, and I think the concern was it was older information, that 71 percent of patients had at least one actual or potential unintentional medication discrepancy.

And then incomplete prescription requiring clarification and causing a delay in obtaining medication was 50 percent, and the omission of medications occurred in 23 percent of cases, and those were the most common unintentional discrepancies. So we did provide that.

However, we do want to provide additional evidence, and it includes one small study, a 2013 study in the Journal of Hospital Medicine, which found that of the study patients, 50.6 percent experienced medication discrepancies. And here we did find that males were 4.34 times more likely to have a discrepancy. So it seems like there is some difference there at least related to gender.

And then, again, the systematic

reviews, and Dr. Casey, you mentioned one of them. They do provide information about medication reconciliation strategies. In the review of the studies that they looked at, they did find a medium proportion of unintended discrepancies across interventions, and this is including the pharmacy-related or the IT-related or the staff education.

They found the discrepancies at 34 percent across the different types of strategies that were implemented.

CO-CHAIR LAMB: Thank you. Comments. Rich.

MEMBER ANTONELLI: Everything that you just said totally resonates, but I'm not seeing the connection between this measure and any evidence that suggests that it is effective in ameliorating any of those gaps. Is there anything that you could --

MS. CHAVARRIA: Yeah. So we usually -- again, unfortunately that's another issue that this Committee will need to determine. We do

usually tend to provide PQRS data for that, and then it will show, you know, 93 percent or 50 percent, etcetera, and those are for our physician level measures.

This has been a little bit of a different beast in that these are facility measures, and we've had more difficulty in getting these implemented, unfortunately. So our intent every time is to bring such performance scores and performance data, and NQF staff will attest to that, we do. Scout's honor. But in this case, that was just not available, and we didn't want to bring information that would obfuscate the -- what we're really trying to get to here.

CO-CHAIR CASEY: So again as a -- I will say that the difference between an error and an adverse drug event is night and day. Errors occur over here and adverse drug events occur over here, and empiric evidence shows that the intersection of the two is about three percent, knowing that it's hard on both sides to measure

in a standard way what we're talking about.

So I just want to point out to the Committee that we shouldn't, in my opinion, conflate medication errors with adverse drug events. I mean they're related but different issues, and so this seems to me to be focused a lot more on the error side, with the hope that you'll have a barrier to preventing adverse drug events.

But I think the way this gets operationalized is, again, here's the list, see you later, and I don't think there's enough in between, as you know. So it's just a nuance that I think is important here.

MS. CHAVARRIA: I do want to add if I may that -- and my colleague here just reminded me, that while our physician level measures are implemented and the facility level ones may not be, we did -- they are just now being implemented in the prime. It's a CMS Medicaid-related program, and this is in California.

They just implemented it last year and

it was last year was a pay for reporting, but now we're going to switch over to pay for accountability, and we should have data. Whether they share it with us hopefully they will, because this is -- we are the stewards and developers of this measure. We expect to be able to have that data in hand. But I'm not sure what the timing for that will be.

MS. GRAY: The timing for CMS data becoming available to measure developers is typically -- it's on a two year delay. So for this year if we were submitting physician level measures, we would receive 2015 data, just to give you an idea.

MEMBER DEZII: For completeness, I don't think -- there wasn't any disparity information either, right?

MS. CHAVARRIA: No. Just the one that I was able to find, in that males were 4.34 times more likely to have a discrepancy. But again as Dr. Casey mentioned, it's not directly related to that. But in terms of we looked for whether

there was a gender, racial, ethnic types of disparities, and there was no information related to that.

CO-CHAIR LAMB: Any other comments before we take a vote on opportunity for improvement?

(No response.)

CO-CHAIR LAMB: Okay. Yetunde.

MS. OGUNGBEMI: We are now voting on performance gap for Measure 0646. Your options are 1, high; 2, moderate; 3, low; and 4, insufficient. Voting is open.

[VOTING.]

MS. OGUNGBEMI: Results are 0 votes high, 3 votes moderate, 4 votes low and 9 votes insufficient. 0 percent high, 19 percent moderate, 25 percent low and 56 percent insufficient. Measure 0646 fails performance gap.

MS. MUNTHALI: So evidence is the only criterion that has the insufficient with exception. So we counted the two low, low and

insufficient, those are grouped together. So that is a fail. The majority, over 60 percent of the Committee voted either low or insufficient.

CO-CHAIR LAMB: Given the looks on your faces, let's step back a minute because that vote means that the measure does not go forward, okay. That's the stopping point on the measure. It's unlike the one we just did, where the measure developers can come back. Do we have an option of rethinking or are we done?

MS. MUNTHALI: You mean rethinking the vote?

CO-CHAIR LAMB: Revoting.

MS. MUNTHALI: Revoting. So ---

CO-CHAIR LAMB: --- if everybody wants to do that.

MS. MUNTHALI: Did you have the same understanding of insufficient as you did with evidence?

CO-CHAIR LAMB: Did everybody understood that if we voted insufficient, this did not go forward? Yes.

MEMBER BECKWITH: Does anyone wish to change their vote based upon the information --

MS. MUNTHALI: We can take -- we can revote. We'll be fine.

CO-CHAIR LAMB: Yeah. Let's do the revote, just to be sure. Everybody's clear now that if you vote insufficient, okay, it stops -- or low. Those two get combined. So everybody ready, everybody clear on the implications. All right. Everybody's clear. Go.

MS. OGUNGBEMI: We're now voting, revoting on the performance gap for Measure 0646. Your options are 1, high; 2, moderate; 3, low; and 4, insufficient. Voting is open.

[VOTING.]

MS. OGUNGBEMI: Results are 0 percent high, 6 percent moderate -- or pardon me, 0 votes high, 6 votes moderate, 4 votes low and 6 votes insufficient. 0 percent high, 38 percent moderate, 25 percent low and 38 percent insufficient. So the measure still fails.

CO-CHAIR LAMB: Okay. We're going to

move on then to the next measure. All right. We are moving now to 647, also PCPI, and Samira, are you first on --

MEMBER KOPLEFF: A quick ask. Could we take two minutes to hear from other Committee members, and I certainly had one point that I wanted to make regarding the other criteria. We gave that same benefit to our previous measure this morning, when we failed on the reliability criteria.

We still sort of followed due process to give the developer the input related to other criteria. So may I --

CO-CHAIR LAMB: Yes, we can do that Emma. So Chris, do you want to just give us the review on the other criteria, reliability, validity and so forth?

MEMBER DEZII: We did get additional testing. The original submission had an overall score for data element testing, rather than a score for the numerator, denominator and exclusions, and only a single kappa value was

reported and this was insufficient. They since have come back, frankly.

I guess it's additional testing, but the bottom line is that that was so powerful that the numerator, the denominator and the exclusions were 100 percent. Therefore, there was no additional execution of the test because you can't divide by zero. Is that correct? Okay.

Which -- which is fine. I mean from a testing standpoint, that's acceptable. That's acceptable. Validity --- or wait. Do we just stay on reliability? I mean it's -- the measure specified, the specifications are specified for a facility. Unit of measurement is discharges rather than patients. That's a little change.

The numerator includes all instances of discharges. The denominator includes all discharges of patients regardless of age from an inpatient facility. The exclusions include patients who die and who left AMA. The measure is not risk adjusted. I think the data elements are defined.

The data from a report --- automatically generated report from an EHR was compared to manual extraction of patient records, to calculate parallel forms of reliability for the measure, and that's for the -- well, it's all I have to say. I mean from a reliability standpoint, with the additional testing it moved to -- from insufficient to -- is this a pass? This isn't a pass/fail is it? No.

CO-CHAIR LAMB: We don't need to worry about that now.

MEMBER DEZII: Oh okay.

CO-CHAIR LAMB: Any other comments on reliability?

CO-CHAIR CASEY: I just had a question. I had a question about whether these data on inter-rater reliability had been upgraded since the '08 submission, and did it include testing inter-rater reliability in the electronic environment, which is where this has gone. So just a technical question that you might want to clarify.

MS. GRAY: Great question. So this is the same testing data that we previously submitted. It's not from 2008 though; the testing projects span from 2009 to about 2011, including some alpha testing and some, you know, focus groups. A lot of the timeline was focused on the focus groups, because that was six different sites that we used.

But the reliability data is from the one site and the automated report was compared to a manual abstraction of an EHR, and that's what's been submitted here. Yes, sure.

CO-CHAIR LAMB: Ellen.

MEMBER SCHULTZ: Yes. As long as we're giving some feedback, I have to say I was having a real hard time being convinced about reliability from just one single site. And then if this is designed to be something where sites can do an EHR poll, then I want to see reliability across sites. Can they even implement that guidance to be able to pull from the EHR, and so that will be something to think

more about if this is a measure you're going to continue to work on.

It sounds like there are plans that are starting to be put in use hopefully, that there will be much more data that you can rely on to look carefully at both the reliability and the validity across sites.

MEMBER O'MALLEY: This is probably more a validity comment than a reliability comment, although they're merged, and that's sort of, where did this list of data elements that's part of a transition record come from specifically?

Why didn't it come from a group of a ED users, who would then tell you what it is they wanted to know after they left the ED, rather than the clinicians who figured out what they wanted to do know? Oh I'm sorry, this is the inpatient right, not the ED. But the same point, same point, the same point. It doesn't matter who.

CO-CHAIR LAMB: Chris, if you would,

did you want to --

MS. GRAY: I just wanted to clarify what the question was. Was it -- were you asking how the data elements were identified initially, or if it was vetted? Okay. So the technical expert panel, I don't have the original composition in front of me.

(Off mic comments.)

MS. GRAY: Oh okay. Then never mind.

CO-CHAIR LAMB: Chris, as you go through validity and feasibility and usability, if you could just hit the high spots of comments that we want to share with the measure developer. You don't need to go through the whole review.

MEMBER DEZII: You know, established by the technical expert panel 11. I think there was a fair, a reasonable concordance there, though I guess your data elements from one -- if it's from one site. So it had, you know, it had face validity with the supporting -- with supporting reliability metrics done. I mean I don't know.

(Pause.)

MEMBER DEZII: Exclusions are consistent with the evidence and there's no risk adjustment. But of course then you don't know how the exclusions affect the performance measures. But it had, you know, it had face validity, low to moderate.

CO-CHAIR LAMB: Keep going. Just focus on the comments of the developers. Feasibility, usability and then we'll just open it --

MEMBER DEZII: Keep going? Oh, all right.

CO-CHAIR LAMB: Yeah, and then we'll open it up to everybody.

MEMBER DEZII: All right. The measure is coded and extracted by someone other than the person examining the original information. I don't think any data elements are defined fields in electronic sources, though you do, you know, you do recognize that it's a non-traditional approach. You did get some guidance -- I have it

here -- you provided guidance on how to address that.

So you know, it was -- it was moderately feasible, though you know reconciliation isn't an electronic or automated process. There's, that's, you know, it's highly hands-on and requires clinical review and decision-making. But again, this measure is just the delivery of a reconciled document, without getting into how it gets reconciled. It's still always a question that will get asked.

Usability, I mean it's being used right now in the prime hospitals, and we await results from that feedback from that. That's all I have to say.

CO-CHAIR LAMB: Thank you. Any other comments for the measure developers on this measure? Emma.

MEMBER KOPLEFF: Rich, you mentioned this at the beginning of our conversation about importance, that I was really struck by the information provided around related and competing

measures, that there's some higher level discussion to be had. I don't know if it's in the vein of gaps or competing measures or both.

But I recognize there's other similar but -- similar measures addressing a similar idea that NQF is reviewing in other places, not necessarily our Committee. I appreciated the developer's comment about looking at this measure specifically through a patient lens, and the patient having that med rec list.

Where I struggled was, I feel we today held that measure to a certain level of importance, and you know I think it was the right one. I'm not in disagreement. But we don't have a sense for this Committee of whether those similar other measures are being held to that same sort of challenging thinking.

I mean we had to vote and revote to get where we needed to go. So I suppose the general ask is taking a look in an ideal world, whether or not this can happen.

The challenge would be for this

developer to have some coordinated discussion with some of those other developers, thinking about a measure that not just looks at after discharge whether a reconciled medication list is documented in the record that has just gone home with the patient, but has been verified and, as was mentioned earlier, really reconciled and provided in more than one place to more than one member of the care team, including that patient. Thanks for that.

CO-CHAIR LAMB: Emma, I would also suggest, you know, in the recommendations from this Committee, certainly the process of the vote and the reasons will be documented, and I think harmonization now has come up several times related to this particular measure. If we don't get to it today, we will have a discussion about harmonization. Rich.

MEMBER ANTONELLI: Under the rubric of trying to derive value, this meets the measure if you can find evidence in the MR that the patient received something. You use the term patient-

centered but how cool would it be if this was a patient-reported outcome, for example? You know so what I'm about to make is an editorial statement, and I'm going to own this as a clinician.

For those of us that labored under meaningful use, clicking boxes, asking two year-olds if they still smoke cigarettes, etcetera, etcetera, that was really challenging. This, however, could potentially be a whole lot better if the patient could say yes, I received that document and somebody walked through my meds with me.

So the way I see this, it's kind of a -- it's sort of a parallel version of MU, but I really love the spirit of it. I think that's why I'm investing as much thought into this as I can. This could really help move things forward. But just another checkbox isn't going to move the field forward. So I would encourage you to think about that.

CO-CHAIR CASEY: I went to a Catholic

grade school but I quite in 7th grade so --

CO-CHAIR LAMB: Before we move on then to 647, I just had recently had the experience of going to my PCP, and I was asked the first question by one of the staff of am I in an abusive relationship. It was the first question I was asked as a new patient, and I looked at the person and said well, I'm not but maybe my husband thinks he is.

(Laughter.)

CO-CHAIR LAMB: Anyway, talk about --- 647, Transition Record, and we're going to move into -- this is a set of Measures 647, 648, 649, all related to transition records and we're going to start with 647. Samira, are you lead? Yes, thank you for reminding me. I keep forgetting.

MS. CHAVARRIA: So I'll go through this just quickly, but before I move on, I do want to thank everyone for your thoughtful comments. I appreciate it and we always take it back to our expert work groups and then see where we would go.

So for Measure 647, it's a Transition Record with Specified Elements Received by Discharged Patients, and the rationale for this measure was to provide detailed discharge information, which will help patients comply with treatment and follow-up plans, so as not to just, you know, you have been discharged, thank you very much, but actually provide them with a plan that they could follow up, and it does include some elements, minimum required elements for the transition record, and then I will let the lead discussants get into that detail.

(Off mic comment.)

MEMBER LEATH: So again, this measure is focused on the transition record with specified elements received by discharged patients, and discharges from the inpatient facility to home, self care and any other site of care. My understanding was that there has not been any new updates to this, and that much of the evidence is based on the systematic review and expert opinion of the panel that met.

Well, it's here, and that I think one of the things that I do recall reading was that there is currently, and I don't know if I'm saying this in the wrong section, but there's currently studies being done and they're anticipating new data being available by two different sources. So let me stop to see if you'd like to add something.

MEMBER BECKWITH: No, except to just comment that as we were looking at this, we really saw this as another process measure and an opportunity to a new word I learned today be a bridge, and have people actually receive some information. I think it's very difficult to know what people have processed.

But it seemed as though this information had been updated in 2012. We were going to recommend that a vote didn't need to be taken on whether or not it needed new evidence or whether or not the evidence was sufficient to continue, just to go ahead and go with the path. But I didn't know if you wanted to add anything

about new evidence.

MS. CHAVARRIA: So I do have some new performance gap evidence that I wanted to share with you, and that again the concern was with the last ones that we provided were from rather old sources. In terms of the -- again, we develop measures based on guideline recommendations, hopefully high level guideline recommendations, but in this case this measure continues to be reliant upon the 2009 Transitions of Care Consensus Policy Statement that was put out by the several groups.

There are no new guidelines that would provide support for this measure. So we did provide the same information unfortunately at this point.

While I do have performance gap info and then I also have just a little bit of additional info on the implementation of this measure, which I will provide a little bit later because somebody had asked about the implementation of these measures in the inpatient

psychiatric facility quality reporting program, and the difference between these two measures and the HBIPS measures.

So that's additional information that I have. But again it doesn't necessarily relate to the guidelines.

MEMBER BECKWITH: I guess the question then is whether or not the Committee believes that we need to take a vote, or whether we let this information stand and it passes.

CO-CHAIR LAMB: Do you want to make a recommendation?

MEMBER DEZII: This is the same evidence base that I covered in the last measure, right, complete same?

MS. GRAY: It is.

MEMBER PACELLA: The previous determination was insufficient with exception; is that correct?

MS. GRAY: Yes.

MEMBER PACELLA: So the real question do we need to revote, that we think that would

come out differently?

MEMBER PACELLA: Exactly.

CO-CHAIR LAMB: It's a different measure. If we think that's the case, we need to vote. So --- we don't need to vote?

MS. MUNTHALI: We could if it's the same evidence. It is the same evidence. We could carry over that vote if the Committee is okay with that, from the prior -- well actually from the prior measure, because it is -- you're saying it's the same vote. So would you -- do you want to vote again or --

CO-CHAIR LAMB: Can the reviewers clarify, because the last one was on medication, reconciled medication. Now we're on to transition record. Is it exactly the same evidence that was used for both?

MS. CHAVARRIA: It's the same consensus policy statement, because it did provide recommendations that support all of the four measures. So we did provide that as in -- as we usually provide the guideline

recommendations on which the measures are developed or are based, we provided this document as the supporting guideline. In fact, it's a consensus statement to support these four measures.

CO-CHAIR LAMB: Just to go back to your comment, which is, the application is different even though the four are in there. Is that still -- does your recommendation still hold?

MS. MUNTHALI: So I'd rather you vote again, and just remember everything we went through with insufficient and insufficient with exception.

MEMBER BECKWITH: Right. Then we would recommend a vote on this, and remembering that it's very similar to the one that we just had on the prior measure.

MEMBER ANTONELLI: So point of clarification. I heard you say that it was the same consensus document, which would be the source of the evidence. That's different than

saying that the information within that document is the same evidence. So could you distinguish that please?

MS. CHAVARRIA: Sure. So we look at the recommendations from guidelines and hopefully they're Level A high quality recommendations. In this case, the 2009 Transitions of Care Consensus Policy Statement put out several recommendations, one related to patients should receive a medication, a reconciled medication list. That's Recommendation 1.

Recommendation, I don't know what the numbers are, and then another recommendation was that the transition record should include these specified elements. So we took that from the same policy statement, but a different recommendation.

MEMBER ANTONELLI: So I guess I want to, for the sake of the record, I want to be really clear. The same source of the evidence may be different and even just the way you just described it qualitatively, I'm willing to give

you and your team the benefit of the doubt that it's different evidence, because I guess I'm having trouble wrapping my brain around the fact that the last measure and this measure are based on exactly the same evidence.

MS. CHAVARRIA: Yeah, sorry. They're not -- they wouldn't be based on the -- they're based on the exact same policy statement?

MEMBER ANTONELLI: Yeah. So it's the source of the evidence. But the question at hand is not the source of the evidence; the question at hand is the evidence itself. So if you could clarify that. Is this -- I don't know whether it's you or it's the reviewer. So if we can get beyond the source of the evidence to what the actual content of the evidence is.

MS. CHAVARRIA: Well, the evidence for the consensus policy statement, which was this group that came together and -- they did not have, because it was consensus-based, they did not have the randomized control trials. They did not have the prospective studies. We needed to

make a graded evidence, because these are not graded recommendations. These are consensus recommendations.

MEMBER ANTONELLI: Okay.

MS. CHAVARRIA: So it was based on their discussion.

MEMBER ANTONELLI: Okay, okay, and does that square with what the discussants and reviewers with respect to --

MEMBER LEATH: Yes.

MEMBER ANTONELLI: Yeah? Okay, thank you.

MEMBER LEATH: But I did have one other question/comment, and you know, I don't know if it goes in this section or another section, but this measure has multiple components to it. I'm saying this measure has multiple components to it, and I guess clarification for me would be can you address whether any aspects of the systematic reviews that are referenced in this document address that?

MS. CHAVARRIA: No.

MEMBER LEATH: Okay, thank you.

MS. CHAVARRIA: Again, because it was purely consensus and we try not to provide consensus policy statements. But in this case that's what the RX Report Group had to work with unfortunately. So they're not graded as we -- and they're not the quality, quantity and consistency of the evidence that we usually provide was not provided here, because of that reason.

MEMBER BECKWITH: Well, and to clarify, there's been no new evidence presented.

MS. CHAVARRIA: There have been no new guidelines with a systematic review of these are the elements that need to be included, yes.

MEMBER KOPLEFF: Just recognizing that one of the elements in this measure is a current medication list, I was just wondering if the consensus-based discussion that stemmed the development of this measure ever addressed or considered -- I guess I'm having trouble reconciling the need for the separate measure we

just reviewed specific to a reconciled medication list.

And I know we've been through and we don't need to rehash the challenges in defining that. But this is including a medication list. Why not take one fell swoop at a reconciled list, recognizing the evidence is short-handed either way?

MS. CHAVARRIA: Unfortunately I -- what the thinking of the expert work group was at the time, and to include that one element within this measure and then include it as a stand-alone measure, I'm not quite sure what it was. I can dig around and find that information. But I'm not sure what it was.

MEMBER KOPLEFF: Thank you, just curious, helping me sort through this.

CO-CHAIR LAMB: John then Ryan.

CO-CHAIR CASEY: So in the guideline world, I think part of the challenge is you're using the word consensus. I think the correct word mostly is expert opinion, consensus of

expert opinion, which is some form of evidence, right? And that was the basis for both categories. I found this study from Australia, which had a number, 12 articles had met inclusion criteria.

Now I didn't check to see if they were all in Australia, but as you go down this, you can see that there were significant gaps in the evidence base, and then I found another one which was admittedly condition-specific, but was in the Annals of Family Medicine from 2015 around heart failure. 41 randomized control trials on transitions of care showing that what they called high intensity transition of care interventions tended to be more effective than moderate or low transition of care interventions.

Now I'm not going to get into a debate about which level of care transition this is, or whether what is present in RCTs for heart failure is generalizable. But it is evidence, so and I again think that it makes me worried about going back to 2009 to base this on expert opinion and

not taking advantage of more current evidence.

So I'd just throw that in, and I didn't go much farther, but someone could probably come up with some additional stuff so --

CO-CHAIR LAMB: Ryan.

MEMBER COLLER: I was going to echo what Don just said, which is essentially I think there has been probably quite a bit more published since that consensus statement. I did want to ask a historical question of the Committee. Since this is going up for maintenance, it has passed previous committees, but we're discussing the same evidence base that we discussed then.

So I'm just curious, because I feel like maybe we're leaning towards an insufficient evidence vote on this one like we did with the previous one. Historically speaking, is that how things transpired in the past or has our criteria for waiting and voting on the evidence changed as a committee over time or --

CO-CHAIR CASEY: I wish Helen were

here but let me take a stab. It has changed over time and in fact NQF has paid a lot of attention to making enhancements over a period of about seven or eight years, to really raise the bar. I think the developers could attest that they've done that. Not to be punitive or make things impossible, but to be more constructive about applying evidence.

Because let's be frank. Ten years ago, around this subject there wasn't a whole lot of evidence, period and now there is. So I think it fits well with the inclination of the way science is moving around these types of, you know, multi-factorial interventions.

MEMBER COLLER: Thanks.

CO-CHAIR LAMB: What we're also saying is along with the evidence growing, the onus on the measure developers for, you know, bringing -- being able to bring that back and you've acknowledged that. Not only are there systematic reviews that have been searched here, there are several in the nursing literature as well which

I'm very familiar with. In fact, a 2016 review of all transitions of care.

So I think where we are is to go back now and review, do another vote on evidence, and the same things go, what we've identified going back to what Alaina was saying was the source --- that Rich clarified, the source is the same, the evidence is different. So we do need to vote on this one separately from our other one. Our last one is same source, different evidence base, okay. Everybody good?

All right. So we're going to vote on evidence now, and we're going to go through the same drill in terms of depending on what the outcome of the first level, we may go to a second level.

MS. OGUNGBEMI: All right. We are now voting on the evidence for Measure 0647. That measure is called Transition Record With Specified Elements Received by Discharged Patients, and this is specifically discharges from an inpatient facility to home or self care

or any site of care. Your options are 1, high; 2, moderate; 3, low; and 4, insufficient. Voting is open.

[VOTING.]

MS. STREETER: Do we also have Barbara Gage available on the phone? If you wanted to vote, Barbara.

(Off mic comments.)

MS. OGUNGBEMI: Results are 0 votes high and 0 votes moderate, 1 vote low, 15 votes insufficient, 0 percent high, 0 percent moderate, 6 percent low and 94 percent insufficient. So Measure 0647 will move on to voting whether the Committee wants to vote for insufficient evidence with exception.

(Pause.)

MS. OGUNGBEMI: So we are now voting on the insufficient evidence with exception, the potential exception to the empirical evidence for Measure 0647. The options are 1, insufficient evidence with exception; and 2, no exception.

[VOTING.]

MS. OGUNGBEMI: The results are 15 votes insufficient evidence with exception and one vote no exception. 94 percent insufficient evidence and 6 percent no exception, so we will move on to performance gap.

(Pause.)

MEMBER LEATH: So in terms of -- and from performance gap, I think I alluded to this earlier. There was no data provided on current performance, and that there are -- while there are two studies that are underway, the data will not become available until I believe it's, and please correct me if I'm wrong, later in this year and then next year.

MS. CHAVARRIA: They will be reported and when they become -- they will be reported in 2017. When they become available to us, I can't tell you. But hopefully, again because they are measures and we're stewarding them and own them, they'll be able to turn that information back to us pretty quickly.

MEMBER LEATH: Samira, I don't know if

you wanted to add something.

MEMBER BECKWITH: I think we've already talked about some of the gaps in the information and in the evidence that the Committee would like to see.

MS. CHAVARRIA: Yeah. So I do have -- I actually found, and this I can actually provide it to you if you would like, maybe at some point. I'm not sure what the best way for me to provide this would be, because the submission for -- this is a gap, and I actually found a study that determined the extent to which the elements included in this measure were done.

So it actually tracked the elements that are recommended within the 2009 Transitions of Care consensus policy. They said let's do a study. Let's figure out whether these are actually being included in the transition record. What the study found was that 97.9 percent of discharge summaries included a diagnosis or reason for admission. So that's good.

99.7 percent had procedures and tests

performed during the admission, which is another one of the elements that is required for this measure. However, 76.9 percent had the principal diagnosis at discharge. 43.9 percent had the lab results at time of discharge. So that would not then meet this measure. 12.2 had studies pending at discharge, a listing of those studies that the patient would then be able to know hey, I need these results.

98.4 had patient instructions. 6.2 had a callback number, which is again one of the elements in this measure. So only 6.2 percent of patients would be able to -- would have access to calling about their admission. 41.9 percent had recommendation for follow-up tests and procedures, and 7.7 percent had resuscitation status, and again those are the exact elements included within our measures, and they varied quite a bit on whether they're provided to patients or not, and our expert work group thought that it was important that all of these elements be provided.

So at least we provide that performance at this point. We don't have the performance data on this measure as specified, which again we would like to do. But because again these two measures, 647 and 648 have just been taken up by the IPQFR, IPFQR program.

MEMBER LEATH: The results that you just spoke about, could you tell me about, you know, whether that was in one facility, multiple facilities? How many participants?

MS. CHAVARRIA: Let me see if I brought that with me. I think --

CO-CHAIR LAMB: While you do that, I just want to thank everybody. I need to get to the airport, so I'll be in touch. I'm turning things over to Don's very capable hands, and NQF it's good seeing you all.

MS. CHAVARRIA: So it was a prospective study done, but only in one hospital.

MEMBER LEATH: And the size?

MS. CHAVARRIA: And the size, it was 377 patients discharged home after

hospitalization.

CO-CHAIR CASEY: Anything else, Brenda? No. Samira?

MEMBER BECKWITH: No.

CO-CHAIR CASEY: Any questions from the Committee or on the phone?

(No audible response.)

CO-CHAIR CASEY: So we were going to proceed with our vote here on the gaps. I think there's some additional information provided by the Committee. It looks like someone from Partners made a comment so we'll proceed.

MEMBER BECKWITH: Before we vote, can you just clarify again that if it's insufficient, then this would stop here?

MS. MUNTHALI: Yes.

MEMBER BECKWITH: Okay.

CO-CHAIR CASEY: Insufficient or low combined.

MEMBER BECKWITH: Insufficient or low, it would stop here.

MS. OGUNGBEMI: We are ready to vote,

we are now voting on performance gap for Measure 0647. Options are 1, high; 2, moderate; 3, low; and 4, insufficient. Voting is open.

[VOTING.]

MS. OGUNGBEMI: Lorna, if you could submit your vote please if you are with us still. Okay, we've got it. Thank you. Results are 0 votes high, 8 votes moderate, 3 votes low and 4 votes insufficient. 0 percent high, 53 percent moderate, 20 percent low and 27 percent insufficient. We've landed in a grey zone, so we are consensus not reached and we will continue.

CO-CHAIR CASEY: Let's keep going with our review. Samira. Use your mic Samira.

MEMBER BECKWITH: Sorry about that.

CO-CHAIR CASEY: It's late in the day.

MEMBER BECKWITH: I forgot to turn it on. Okay. We go down to reliability and let's see. As we noted, the patients who are excluded were patients who died and patients who left against medical advice or discontinued care. I think the data elements were very clear in terms

of what was included in the transition plan and I don't know that we have much else to add under that.

But we didn't have any comments in that area, but it was found to be insufficient in terms of reliability.

MS. GRAY: So we provided some additional data for reliability testing for this measure.

MEMBER BECKWITH: Okay.

MS. GRAY: There's -- we calculated kappas for the different required -- the different required measure components, the numerator reliability was .69; the denominator reliability showed 100 percent agreement. The exception reliability also showed 100 percent agreement, and then overall reliability for the measure was .69.

So then that demonstrates that the measure has a substantial level of agreement as far as reliability.

DR. TERRY: I just want to mention

that was provided by PCPI after our work group call, upon request. So everybody should have gotten copies.

MEMBER BECKWITH: Oh, okay. Great, thanks. Somehow I missed it. So I don't have anything else against -- under reliability, unless Brenda you do.

MEMBER LEATH: No, I don't have anything else because --

(Simultaneous speaking.)

CO-CHAIR CASEY: Anyone have any questions or comments?

(No audible response.)

CO-CHAIR CASEY: Yes Ellen.

MEMBER SCHULTZ: So as I brought up with the previous measure, I am really concerned about generalizability of this reliability testing, because it was done just at a single site with a fairly small number of charts. It's not really clear to me how easily the EHR poll guidance could get implemented at multiple locations, and perhaps I think there was a

statement within the package that sort of spoke to why there was guidance provided instead of, you know, particular e-measure specifications.

That raises some concerns for me. So I don't know if there's anything you want to say in response to that. I'm interested to hear what others on the Committee think. But considering how much has changed around EHRs since the time of this testing, and just how much variation there is in terms of how things are documented within EHRs, I have a hard time really trusting the reliability testing from one site, because this is sort of comparing the EHR poll to like, you know, a gold standard of doing chart review.

But really what I'm interested in is like how is the reliability across sites for an EHR poll since that's much more likely to be the way that this is implemented in my understanding. If instead, you know, at least some of the sites that are implementing this now are engaging in chart review, you know, then you want to look at the inter-rater reliability for different chart

reviewers.

But regardless, I feel like you need to see across places, because this kind of information is likely to be documented in really different ways in different places.

CO-CHAIR CASEY: So Ellen, I think you're not quibbling with what the reliability data is that was provided. You're only raising the point that you wonder if -- how that would change in a more electronicized, if that's a word, environment?

MEMBER SCHULTZ: Yes, I'm raising concerns about generalizability, and I think that was one of the questions --

CO-CHAIR CASEY: From the one site as well, yeah?

MEMBER SCHULTZ: From the one, right, yes. So you know, as far as I'm concerned, yes the reliability was good comparing the automated EHR poll process to, you know, a manual chart review. But as I said, this is at just one location and it's not --

CO-CHAIR CASEY: So there's really two points, yeah, right.

MEMBER SCHULTZ: Yeah, yeah.

CO-CHAIR CASEY: Good. Terence, Terry?

MEMBER O'MALLEY: Yeah, a follow-up on point two is sort of the generalizability of the process of getting the data. I think that really is critical. I think that goes back to the specifications of the data elements and sort of how tight those are, because having done a project very similar to this for ten years, it took us multiple cycles to get the data elements constrained to the point where we could actually say whether it was present or absent.

I just didn't see that sort of level of data, and that concerns me for a national measure. For a within one organization measure, fine, go do it. But it's not -- I can't see it moving beyond just sort of one-offs.

Important as it -- and by that I don't mean to dismiss this. I think this is critically

important. I think you're on to absolutely the right thing. My concerns are that it's just not specified enough to make it generalizable.

CO-CHAIR CASEY: Terry, let me ask you to make a hypothetical guess, again not that we would attribute any finality to it. But given that around, right sort of after this period of the initial reliability testing, I guess this is to Ellen too, there was obviously much more emphasis in the health care system on electronic health records and with the advent of readmission penalties a lot more on care transition.

So what would you predict in terms of whether this would be more reliable, the same or less? Do you have any thoughts? I'm just curious about it, because we're obviously not going to get a concrete answer. I'm just worried about, I'm wondering about your impressions.

MEMBER O'MALLEY: I think a lot more people are doing it and they're pulling data, so that they -- again, for internal quality improvement use. So but whether what they're

pulling is the same from site to site I think is the issue. So my bet is that a lot more people are looking at exactly these data elements. They're looking at them in very different ways.

They're all valid for quality improvement, and no one would quibble. They're all getting benefit out of doing it. But my concern is that there's no uniformity across. So my bet is there's less uniformity but more people are doing it.

CO-CHAIR CASEY: And CMS developed a CARE tool which I know they intended to make standard, but obviously --

MEMBER O'MALLEY: Barbara Page's --

CO-CHAIR CASEY: Yes, just in time. But obviously that wasn't adopted as a formal consistent set of data for a lot of reasons.

MEMBER O'MALLEY: Yeah. It wasn't -- it's a nice data set, so it's a standardized data set and actually all of the data elements are linked back to standardized codes. So you can actually use the CARE Data Set as a library of

data elements. I'm not aware of who's actually using it that way, however.

MEMBER COLLER: Right, right. I know. I was just going to piggyback on what Terry and Ellen both said with a concrete example. So I can imagine that within an institution, how they define whether or not cases met the criteria for a plan for follow-up care for example might be -- I think there's a start of a definition here, but it's not --

There's a lot of room for interpretation, I think, of how to meet that particular definition. And so if you define it a certain way in one institution you might get a certain level of performance and at another institution if they interpret that slightly differently you will see variation, and that starts to get into validity a bit. But that was the concern I had, which is I think related to both of these comments.

CO-CHAIR CASEY: Okay. Yes Terry.

MEMBER O'MALLEY: If I could give a

follow-up, just an example of what we did. So giving a phone number for follow-up test results. In our initial round, everyone gave us a phone number. It turns out some of the phone numbers didn't work, some of the phone numbers were to the main switchboard of the hospital. So the patient would call up. I'm calling for my lab results and they say who do you want to talk to and which lab, which person, which doctor?

So we actually had to drill down, so that the criteria became not giving a phone number, but giving a phone number that actually got to the information that individual wanted. We tested samples of that. But it just shows you how you've got to constrain this stuff or you'll get things that --

CO-CHAIR CASEY: You must have residents.

MEMBER O'MALLEY: We have lots of residents.

CO-CHAIR CASEY: Any other thoughts before we vote on this?

MS. APURA: I would like to make a comment why this measure is not specified as an e-measure because every facility may have a different template for a care transition record. And then the information required for this measure is based on individualized patient information that is unique to one episode of care.

And also given that as you've mentioned, even the variability of the structured data across facilities, it would be challenging to specify it as an e-measure that would cover all possible data elements. So that's why this measure is not --

CO-CHAIR CASEY: It's a good point, and it always rubs up against NQF's challenge to endorse measures for accountability, which is I think what we're debating, versus what's the -- not that those two are separate, but in the real world, you know, of quality improvement. So the point is well taken. So Ellen.

MEMBER SCHULTZ: Well, I would just

respond. All those reasons you just pointed out are exactly why I feel like I need to see reliability testing at multiple sites.

MS. GRAY: Yeah. I think this -- the testing and the development of the measures predates pretty much all of us. But the testing project, you're right. It's a small sample size to be frank.

The testing project was -- for reliability was conducted at a health practice that was a Tier 3 medical home and it's -- it was just the one site that deals with seven to eight thousand discharges per year. Even though it's a large facility, I'm not really sure why they only decided to pull a sample of 100 patients, I'm sorry of 100 discharges in order to look at the measure. And I know that, you know, we generally provide -- we generally perform reliability testing with larger data sets that include lots of facilities like or physicians like the PQRS data set, things like that.

So in -- this is something that we

would obviously take back as a recommendation to perform an updated testing project that would include multiple sites, and so that we could demonstrate, you know, better and you could feel better about, you know, supporting the measure, knowing how it would perform on a national scale versus just that one facility. So it's a really good point.

MEMBER SCHULTZ: Yeah.

CO-CHAIR CASEY: Ryan? I'm sorry Ryan. Go ahead Ellen.

MEMBER SCHULTZ: I was going to say for my money, more sites is more important than the sample size at each site. It's the number of sites is the N that I --

CO-CHAIR CASEY: So let me mark time. Who has to leave by four?

(No audible response.)

CO-CHAIR CASEY: All right, good. And let me ask our colleagues from PCPI, do you expect that a lot of what we're debating here is going to trickle into the next two measures as

well? Okay, good. So just keep that in mind, knowing that there will be differences so we can move ahead and get our work done, okay. Not that I'm rushing you, but we're going to go to the vote.

MS. OGUNGBEMI: Yes. We are now voting on the reliability for Measure 0647. The options are 1, high; 2, moderate; 3, low; and 4, insufficient. Voting is open.

[VOTING.]

MS. OGUNGBEMI: Results are 0 votes high, 4 votes moderate, 6 votes low and 5 votes insufficient. 0 percent high, 27 percent moderate, 40 percent low and 33 percent insufficient. Measure 0647 fails reliability.

CO-CHAIR CASEY: And then this is a must pass, correct? So we are back to where we were. Let's continue on with just finishing, you know, as quick and dirty as you can the review of the rest of this report, and then we will take a 6.5 minute bio break, okay.

MEMBER HOHL: Don, this is Dawn. I am

on the next measure, and I do need to get in the car and start driving at 3:30. I think I could probably a remember a lot, but I would not have all my notes in front of me. Just so that you know.

CO-CHAIR CASEY: Thanks Dawn, and Karen is here to help. So Karen, we'll ask you to step up if you don't mind and Dawn you can fill in. But I think the good news is probably a lot of the discussion is going to be echoed with what we've got. So she's good.

MEMBER HOHL: Right, right, okay.

CO-CHAIR CASEY: Thank you.

MEMBER HOHL: Okay. We had broken it up, so I think we had a little bit of a system. So I appreciate that, thank you.

CO-CHAIR CASEY: Great, and you'll continue to vote too, right?

MEMBER HOHL: Well, can I email someone to vote?

CO-CHAIR CASEY: You can email or you can whisper it on the phone. We won't listen.

MEMBER HOHL: Okay, okay, okay.

CO-CHAIR CASEY: Thanks.

MEMBER BECKWITH: Yeah, okay. So the validity testing is next, and I would say it's the same issues that come up under validity testing, in the fact that it was one site and some of the same discussion that we just had about reliability. So let me just ask if people have comments or Brenda, if there's something you want to add or our developers want to add.

MEMBER LEATH: No. I would echo what you just said, just indicating that the method for validity was based on face validity and I don't know that I have any other additions.

CO-CHAIR CASEY: You think we've captured most of the spirit of this in the -- okay.

MEMBER BECKWITH: Under reliability.

CO-CHAIR CASEY: Any other comments on the reliability? You want to keep going?

MEMBER BECKWITH: Uh-huh, okay. And we don't have to vote after --

CO-CHAIR CASEY: Nope.

MEMBER BECKWITH: Okay, so then we go to threats to validity, and I think -- so that discussion we've already had also, in terms of needing to have studies over different sites, maybe additional numbers in those sites. I think we've had that conversation, but I would ask if anybody has anything to add.

CO-CHAIR CASEY: Anything Barbara? You good? Anyone on the phone?

(No audible response.)

CO-CHAIR CASEY: So --

MEMBER BECKWITH: Okay. So as to the --

CO-CHAIR CASEY: Feasibility.

MEMBER BECKWITH: Oh feasibility. Well, in terms of being repetitive, for feasibility I think we've also had that discussion and would ask if anybody has anything to add.

CO-CHAIR CASEY: Well, I would just speculate that my hypothetical question to Dr.

O'Malley would posit the question of, you know, whether with the increased intensity of activity around this particular issue by virtue of many factors in the environment, that we would hope this would become more feasible in the present day and future.

MEMBER BECKWITH: I think that was a very good --

CO-CHAIR CASEY: That's a decent assumption, although it's speculative.

MEMBER BECKWITH: I think and am very hopeful that that would be happening, and I think that we would hopefully see some difference with some more testing across sites.

CO-CHAIR CASEY: Thank you. Good. So anything else on the list here? Are we good?

MEMBER BECKWITH: Feasibility and use.

CO-CHAIR CASEY: Use, usability.

MEMBER BECKWITH: Yes.

CO-CHAIR CASEY: Use and usability.

MEMBER BECKWITH: Right, thank you. Usability and use.

CO-CHAIR CASEY: I guess it depends on all the other factors, would you say?

MEMBER BECKWITH: Yes, I would.

CO-CHAIR CASEY: Good.

MEMBER BECKWITH: Any other comments?

CO-CHAIR CASEY: Any other comments?

MEMBER LEATH: I just have one.

CO-CHAIR CASEY: Yes Brenda.

MEMBER LEATH: You know, I think that there is potential with this measure, and I think, you know, I don't want to beat a dead horse, but probably with further definition and specificity and, you know, having a larger test would yield something, a totally different picture.

So I just want to impart those words to you, because I do see the relevance of the measure.

CO-CHAIR CASEY: And I think you're saying this is such a high stakes issue that we really are attempting to make this work well because the stakes are even more higher than

they've ever been, and that this is -- it's important for us to get it right, and that's why this committee is spending so much duty and care to really analyze this so --

MEMBER LEATH: Thank you for saying that so eloquently because yes, care coordination doesn't get its just due, and I mean that's a very critical element. So yes, thanks.

CO-CHAIR CASEY: Good, okay. 6.5 minutes for our break, and then we'll be back, okay.

(Whereupon, the above-entitled matter went off the record at 3:20 p.m. and resumed at 3:27 p.m.)

CO-CHAIR CASEY: Our PCPI colleagues have a flight to catch pretty soon, so it's in their best interest and ours to maybe even finish a little early. So let's work really hard to try to get through this, knowing that there's a lot of discussion. Karen is going to lead off. I called myself, because I'm a little hoarse, the godfather and she's the godmother. So Karen, do

you want to take us home?

MEMBER MICHAEL: Great, thank you. So the next one 0648 looks at that same discharge document you're talking about, and its intent is to measure the timeliness of the delivery of that document to the next care step, primary care physician, facility or other health care institution that's going to do follow-up care. I don't know if we need to have the developers with their comments to start?

CO-CHAIR CASEY: Is Amy here? Can someone work the screen for us?

MEMBER MICHAEL: So in terms of -- did you want to make introductory remarks?

MS. CHAVARRIA: Thank you, yes. So this measure assesses the percentage of discharges from an inpatient facility for which the transmission record was transmitted within 24 hours of discharge. Now someone did mention, and I wanted to make sure that I address it. Someone did mention in the standing committee comments that this measure should be a companion to the

other measures perhaps, and the PCPI expert work group developed Measures 646, 647 and 648 as a bundle.

However, we do find that implementers may split the measures as needed for their particular programs, but that was what the expert work group would have preferred for these measures to actually be taken together.

Again, the rationales for communication and information exchange should occur in an amount of time that will allow the receiving provider to effectively treat the patient based on condition or diagnosis. That's the crux of this measure and that is the intent, and it is based once again on the 2009 Transitions of Care Consensus Policy Statement.

MEMBER MICHAEL: Which takes us right to evidence, thank you very much. So the same discussion we had with 647, the same consensus document was used here. So if you remember, we went to a vote last time on this, and the ultimate vote was insufficient with exception.

So we have the same evidentiary basis for this one, and unless there are other comments, we probably can proceed to the vote.

CO-CHAIR CASEY: Anyone object to that? Dawn, yeah I'm sorry. Chris, and Dawn, are you on the phone?

MEMBER HOHL: Yes, I'm here.

CO-CHAIR CASEY: Are you in your car yet or not?

MEMBER HOHL: Yes, I'm in the car.

CO-CHAIR CASEY: Okay. So if you're driving, just whisper.

MEMBER HOHL: Well I don't even need to whisper. I would vote insufficient with exception.

CO-CHAIR CASEY: Thank you. Well, we're going to vote first on the first process, and then we'll vote second. So we vote --

MEMBER HOHL: Oh, I'm sorry. I jumped ahead, I'm sorry.

CO-CHAIR CASEY: So you're going to vote for, okay.

So Yetunde.

MS. OGUNGBEMI: Yes. We are now voting on Measure 0648, Timely Transition Record With Specified Elements Received by Discharge Patients, and this is also discharges from an inpatient facility to any other site of care. Your options are 1, high; 2, moderate; 3, low; and 4, insufficient. Voting is open.

[VOTING.]

MS. OGUNGBEMI: Results are 0 high, 0 moderate, 1 low and 14 insufficient. 0 percent high, 0 percent moderate, 7 percent low and 93 percent insufficient. So we will now vote on whether the Committee wants to do a vote for insufficient evidence with exception.

CO-CHAIR CASEY: Deja vu all over again. Let's go.

MS. OGUNGBEMI: We are now voting on Measure 0648, evidence on -- the empirical evidence with an exception. Your options are 1, insufficient evidence with exception; and 2, no exception.

CO-CHAIR CASEY: And we have Dawn's vote too.

[VOTING.]

CO-CHAIR CASEY: We have it? Are we good?

MS. OGUNGBEMI: We need to revote because -- we need to revote. Just give me one second.

MEMBER MICHAEL: We have more votes than people. We're in Washington, D.C.

(Laughter.)

MS. OGUNGBEMI: That's okay.

(Pause.)

CO-CHAIR CASEY: Ready, and we already have Dawn's vote so --

MS. OGUNGBEMI: Voting is open.

[VOTING.]

MS. OGUNGBEMI: Yeah, we're missing one vote. Oh, got it. Results are 13 votes insufficient evidence with exception and 2 votes no exception. 87 percent insufficient evidence with exception, 13 percent no exception. So we

will go to performance gap.

CO-CHAIR CASEY: Karen.

MEMBER MICHAEL: Okay. So with respect to performance gaps, as we said with the prior measure, there is no data on this current measure. There is a lot of data out there on the impact of untimely discharge communication, and the negative effects that has on care. There's a more recent article even than the one that you guys have from 2016 Journal of Hospital Medicine, that concluded the same thing.

Longer days that can lead discharge summaries were associated with higher rates of an all-cause readmission. Timely discharge summary completion time may be a quality indicator to evaluate current practice, and a potential strategy to improve patient outcomes.

So while there's no data for this specific measure, there's definitely data out there that shows there's performance gaps in this area.

CO-CHAIR CASEY: Dawn, do you have

anything you want to add on gaps?

MEMBER HOHL: No Terry, not at all. Thank you.

CO-CHAIR CASEY: Any questions on this? Yes, Samira.

MEMBER BECKWITH: I just wanted to comment that when the commenter comments notes about the skilled nursing facility, and just when this is being reviewed or being presented in the future, I think that really has some merit. The SNF, the other locations that someone might be transferred to, that 24 hours is not going to be helpful and they might turn around and end up back in the emergency room or back in the hospital. So, I just wanted to point that out.

MEMBER MICHAEL: Yeah, I would agree that 24 hours is a long time. But I think again it's a place to start.

CO-CHAIR CASEY: It's a floor. Terence.

MEMBER O'MALLEY: Just to make a comment for the at discharge criteria, because 24

hours is a lot better than what it used to be, which in our hospitals was 30 days by law --

MEMBER MICHAEL: Right, until it was dictated and signed off.

MEMBER O'MALLEY: Then you had another 30 and then another 15 before anything happened.

MEMBER MICHAEL: I'm old enough to remember that.

MEMBER O'MALLEY: It's a huge improvement to get it to 24 hours, but the reality is that readmissions occur in that first 24 hour gap, and so if you don't have the data when the person shows up in the ED, that's a major quality issue.

And then specifically the SNF issue, that the discharge paperwork is actually the new orders, so that you cannot really begin care without them, and that's important. So just I think at time of discharge is a reasonable approach.

CO-CHAIR CASEY: Good points. So, ready to vote on this performance gap? Ready?

MS. OGUNGBEMI: We are now voting on performance gap for Measure 0648. Your options are 1 high, 2 moderate, 3 low and 4 insufficient. Voting is open.

CO-CHAIR CASEY: And Dawn, we're holding our ears for your vote so --

MEMBER HOHL: Insufficient.

(Voting.)

MS. OGUNGBEMI: Results are 0 votes high, 7 votes moderate, 1 vote low and 7 votes insufficient. Zero percent high, 47 percent moderate, 7 percent low and 47 percent insufficient. We are -- we've reached -- we have not reached consensus. We landed in a gray zone, so we will continue on to reliability.

MEMBER MICHAEL: Okay. With respect to reliability, the data provided mirrors the data provided for 647. There was updated reliability information provided showing the numerator and denominator reliability of 100 percent. However, the same issues we talked about last time -- a smaller sample size and

testing -- are still present.

MEMBER HOHL: And Karen, the only thing I would add to that, there was an exclusion in the data that was not clear to me, that there was an exclusion of cancer patients who died. I'm not sure why all patients who died would not have been excluded.

MEMBER MICHAEL: Yeah, thank you Dawn. I thought on the call we had clarified that that was actually a typo.

MEMBER HOHL: Did we? Okay. We --

MEMBER MICHAEL: Yeah, the exclusion --

MEMBER HOHL: -- may have, maybe I missed it.

MEMBER MICHAEL: Well, for the record that's good to point out. For the record, the exclusion should be all patients who died and patients who left against medical advice.

CO-CHAIR CASEY: And I think that the generic feeling here is that not only does the measure of timely transmission have to be reliable, but the reliability of the content is

important too, right? So these two -- even though they're --

MEMBER MICHAEL: Well I mean that's a little -- that's a little nebulous in the way the specs are written, because they're looking for the transmission here. But we're not really measuring the elements as part of the --

CO-CHAIR CASEY: I understand.

MEMBER MICHAEL: Which is why I think the developers saw a bundled approach to the measures, which does make sense.

CO-CHAIR CASEY: Yeah.

MEMBER HOHL: But I think that might speak also to -- I looked in the literature review. When you do a discharge summary, it's seven days, one day, 30 days after the patient's discharge, you then have to start questioning the accuracy of it, if it's not done at that time of discharge.

So I would actually advocate if there's any possibility to look at it as a best practice, that it be at the time of discharge,

again because of the accuracy. It would be more likely than any time thereafter.

CO-CHAIR CASEY: Terry.

MEMBER O'MALLEY: Not to belabor the point, but having the specs -- really tight specs on what you want the content to be. So here's the discharge packet and then it's got to meet the standard of a good discharge packet. I think that's really critical for this measure, because if you're just sending garbage that -- even if you do it in a timely fashion, it doesn't get you anywhere.

CO-CHAIR CASEY: Rich.

MEMBER ANTONELLI: So I'm going to poke you a little bit on that one, because -- and I don't know whether PCPI team feels the tension here with these being considered as a non-bundle, as I would argue that the first measure gets at the content. The second one is the timing, and so I think in the context of unbundling the bundle, this measure is only about timeliness.

I don't know whether I'm going to be

out of order or not but I'll frame this. Is it okay that we proceed with these in unbundled fashion? Is that acceptable to you? And is it fair to me to ask them, because I don't want to overstep the chair's responsibility here.

MEMBER ANTONELLI: It's okay for you --

(Off microphone comments.)

MEMBER ANTONELLI: Yeah, okay, all right, thank you, because obviously I totally agree with him. But in the context of this measure, I have to disagree with him. Okay.

CO-CHAIR CASEY: Okay. Good thing the Bostonians are over there. The Committee ready to vote? Let's go.

MS. OGUNGBEMI: We are now voting on reliability for Measure 0648. Your options are 1 high, 2 moderate, 3 low and 4 insufficient. Voting is open.

MEMBER HOHL: This is Dawn. I vote insufficient.

(Voting.)

CO-CHAIR CASEY: We got them.

MS. OGUNGBEMI: Results are 0 votes high, 4 votes moderate, 4 votes low and 7 votes insufficient. Zero percent high, 27 percent moderate, 27 percent low and 47 percent insufficient. So Measure 0648 fails reliability.

CO-CHAIR CASEY: So we're again really following the pathway of the other two measures. Karen, do you want -- do you want to add anything else to your elegant review?

MEMBER MICHAEL: If we need to go through the rest, we can. But I think it's going to pretty much mirror what we saw for the previous measure.

CO-CHAIR CASEY: Just at a high level, just --

MEMBER MICHAEL: Sure. So for validity testing, there was updated information submitted on the face to face -- face validity, again smaller numbers. But they did show moderate strength of agreement.

On feasibility, these are elements

that can be extracted from the record. And ideally you'd find them in an EMR, but if not you can abstract them from the record. So it does have a moderate -- or a preliminary rating of moderate for feasibility, which I agree with.

CO-CHAIR CASEY: I think I saw -- maybe it rolled by -- a kappa of .49.

MEMBER MICHAEL: I'm sorry?

CO-CHAIR CASEY: I think I saw the kappa was .49 in this measure.

MEMBER MICHAEL: Yeah, .49 for validity, right.

CO-CHAIR CASEY: For validity, right.

MEMBER MICHAEL: Which is moderate. So feasibility is moderate, and then for usability and use -- again this is one of the measures that was picked up by the Inpatient Psychiatric Facility Quality Reporting Program. So results for the measure themselves should be coming available later this year and hopefully would be available when the measure comes back. But in my opinion, it's definitely something we

should be measuring and taking action on.

CO-CHAIR CASEY: Thank you. Any other comments? Dawn, you good?

MEMBER HOHL: Yes. I 100 percent agree.

CO-CHAIR CASEY: All right. Let's get out of here. Let's have Charissa and Terry bring us home. Do I have that right? I'm sorry. So we're on the final one point, 0649.

MS. CHAVARRIA: Thank you. So this measure is Transition Record With Specified Elements Received by the Discharged Patient, and this is from the emergency department discharges, as opposed to the other one, which was from inpatient discharges. The rationale for this measure is that it was developed to help ensure that patients receive the information to care for themselves at home, and be able to follow up as needed to manage their injury or condition after an emergency department visit.

Again, our expert work group thought this was an important thing to measure, and it is

based once again on the 2009 Transitions of Care Consensus Policy Statement. I have some -- we do not have performance data on the measure as specified, as this measure unfortunately has not been picked up for implementation that we know of.

So all the other ones we're waiting for data. For this one, we're not exactly sure whether it has been implemented and whether data will be available. We have not identified any programs that do that.

MEMBER PACELLA: All right. So as summarized by the measure developer, this is -- the data presented in support of this measure was similar to the other measures and was based on expert consensus. No new evidence or data has been presented.

We are not aware of any other new data that exists that wasn't presented in this arena, although I would note separately that the 2017 lens tells us that things are quite different in this realm probably than they were ten years ago,

because the ED transition record was part of one of the meaningful use things that many places anticipated was going to be implemented, even though it wasn't.

So I think without current data, it would be very hard to even say that expert consensus today would be the same. So in that lens it, you know, seems like a good idea to send people home with the information on the list, but I guess we're on the practice of evaluating evidence.

There were not other questions that were raised on the call related to this, and so I think without any other additional or new information, we could go ahead and vote on the evidence previously presented. And again, recognizing that the previously submitted comments from the prior Committee evaluation included the fact that there are no ED discharges looked at in any of these measures.

So none of the data applies to discharges from the ED, either reliability or

this one.

CO-CHAIR CASEY: Terry, do you have anything to add?

MEMBER O'MALLEY: No.

MEMBER PACELLA: We just -- we talked in advance.

CO-CHAIR CASEY: I did have a study from the VA QUERI, Q-U-E-R-I, which is their Quality Improvement Research Group from January 2015, who did an elegant systematic review that I didn't mention before about transitional care and mentioned explicitly in that review that very little had been done in other settings outside of the hospital, which I think probably still includes the ED.

But for the most part, the bulk of the evidence is on the hospital side. So we have work to do. So let's -- if there's no further comment, let's vote.

MS. OGUNGBEMI: We are now voting for Measure 0649, evidence. Your options are 1 high, 2 moderate, 3 low and 4 insufficient. The title

of this measure is called Transition Record With Specified Elements Received by Discharge Patients, and this is from emergency department discharges to ambulatory care or home health care.

(Voting.)

MEMBER HOHL: This is Dawn. I vote 4.

MS. OGUNGBEMI: Results are 0 votes high, 2 votes moderate, 1 vote low and 12 votes insufficient. Zero percent high, 13 percent moderate, 7 percent low and 80 percent insufficient. Measure 0649 passes on evidence. And does the Committee want to go to insufficient evidence with exception?

MEMBER PACELLA: Go.

MS. OGUNGBEMI: We are now voting on insufficient evidence with exception for Measure 0649. Your options are 1, insufficient evidence with exception, 2 no exception.

(Voting.)

MEMBER HOHL: This is Dawn. I vote 1.

MS. OGUNGBEMI: Results are 11 votes

insufficient evidence with exception, 4 votes no exception. Seventy-three percent insufficient evidence with exception, 27 percent no exception. We can move to performance gap.

CO-CHAIR CASEY: Charissa.

MEMBER PACELLA: Okay. So summarizing the data on performance gap, there really was not any data related to performance gap presented related to this measure that has looked at any emergency department discharge. So there is virtually non-existent data in this realm, so we can all make our best guess as to whether a gap exists. Sorry.

MS. CHAVARRIA: We had a tough time with this one. There's very limited data or hardly any. But we were able to find a 2011 study that found that 76 percent of patients received an explanation of their symptoms, and 30 percent of patients received instructions about symptoms that should cause them to return to the ED.

Additionally, in terms of examining

written ED discharge instructions, but this was specific to different types of patients. So for hypoglycemic patients, we would hope for broader. But it revealed that many were missing key components of home management and patient safety.

For example, only 21 percent were advised -- patients were advised to frequently monitor their blood glucose, and then another study of discharge instructions for patients prescribed acetaminophen containing narcotics found that no patients were instructed to avoid the use of other acetaminophen-containing medications. So these were smaller studies but we were able to find them.

MEMBER PACELLA: Yeah, and so I think there's -- you know, my impression is that there's a lot of things that address small pieces of this.

MS. CHAVARRIA: Yeah.

MEMBER PACELLA: The real problem that I think we run into here is that it would be really helpful to actually have a sample of cases

that look at today, because even five years ago in this realm is not today. And so I think that what might pass that muster several years ago in anticipation that more data is coming, when no more data is collected and no more evaluation is done it becomes a little stale to say okay, well we'll just keep waiting until somebody implements it or gets the data. So that's my -- that's my kind of worry about that.

CO-CHAIR CASEY: Charissa, is there a My ED transmission record app yet that's secure?

MEMBER PACELLA: I would really like to have a fully shared record with the patients and have them own their record, but that's my future state.

CO-CHAIR CASEY: Okay, sorry.

MEMBER PACELLA: All right, no, quite all right. There is a myUPMC, so -- I'm not advertising that. Okay. So are there other comments related to performance gap from anyone else? I mean if there aren't, we should --

CO-CHAIR CASEY: Shall we?

MEMBER PACELLA: -- vote on performance gap.

CO-CHAIR CASEY: All right. We know how to do this.

MS. OGUNGBEMI: We are now voting on performance gap for Measure 0649. The options are 1 high, 2 moderate, 3 low and 4 insufficient. Voting is open.

MEMBER HOHL: This is Dawn. I vote 4.

(Voting.)

CO-CHAIR CASEY: I always get nervous when we're talking about EDs and the sirens are going off in the background.

MS. OGUNGBEMI: Results are zero votes high, 2 votes moderate, 1 vote low and 12 votes insufficient. Zero percent high, 13 percent moderate, 7 percent low and 80 percent insufficient. Measure 0649 fails on performance gap.

CO-CHAIR CASEY: And that's a must pass, right? So we are -- we're stopping here, although if you could just fill in any remaining

blanks for us specific to this measure, you and Terry, we'd appreciate it.

MEMBER PACELLA: Sure, and so it's a failure primarily due to lack of evidence rather than -- or lack of data rather than any other specific criterion. Under validity testing, same issue. It was the same data presented for the prior studies, so I would just echo the same comment, that certainly for an emergency department-based metric it would need to be emergency department discharges probably that were looked at, because we're presuming processes are the same and I can guarantee they are not in most places.

And then on the other side, you know, more than one site would be helpful. Those comments were made. Under threats to validity, there was the added concern that if there's going to be face validity testing for a measure like this, it should probably include some people with knowledge of emergency department care or processes.

So looking down the list of people from the validity testing, it didn't look like there was anybody there who would have necessarily expertise in the area of emergency care, although two of the original 38 developers or whatever did.

And then those -- so that comment was made. It seemed like feasibility was good potential, especially with EHR advances recently, and likewise usability. I wonder if the fact that it's not in use is more a reflection of people's perceived value, that this is already sort of mostly being done and that filling in whatever gaps exist may not be of very high perceived value.

MEMBER O'MALLEY: And if I could just add two comments, I guess. One is, again, the choice of what to include in this discharge packet. I just respectfully submit that asking individuals who are users of the ED what they would value most leaving the ED might be a good place to start, because that might get you more

towards full validity.

And then the second -- and this is probably not fair because it's going back to the other med rec, medication piece. It's just again around specifics, about how you define your data elements and -- maybe I'll follow up on that one if we have time to go back on medication-specific, because it doesn't really apply to the ED. So, withdraw that comment.

CO-CHAIR CASEY: Well, so it's okay. I mean you're not on the record. But the word packet makes me very nervous because the packet I usually get is one page of useful information and ten pages of, you know, why did I hate my mother when I was in 6th grade and, you know, blah blah blah. I actually loved my mother when I was in 6th grade, but you know what I mean. There's all this stuff there that is like just print it out, right.

MEMBER O'MALLEY: So you obviously don't work at Partners, where you get a 40-page discharge packet.

(Laughter.)

CO-CHAIR CASEY: Thank you. So, any other comments for this? So let's mark time. It's four o'clock. I want to let -- Rich, go ahead.

MEMBER ANTONELLI: Just in terms of enhancing the value, I think this would be a great measure if it was receipt by somebody, so transmitting at the time of ED discharge. But I'd love to be able to look at this as a performance measure, you know, and then you can -- it could be the medical home, it could be the subspecialist, it could be the SNF, wherever the patient is going. But I'd love to see a measure that really pushes that integrated care opportunity.

CO-CHAIR CASEY: Yes, Charissa.

MEMBER PACELLA: As much as we all, you know, love and don't love the CAHPS projects, I have to say it is one of the things that I think is actually probably more beneficial than something like this has been, that they're asked

the question did you get information about your medications, did you understand it, which I think is a much more patient-centered approach than did we push the 12 pages of information out to you.

CO-CHAIR CASEY: And are you on the right medication and are you getting better and, you know, how are you feeling and -- right? So -- sorry. So, I know our friends from PCPI have to Uber their way to Reagan. Let me before they go say first of all thank you. I know that in some regards you're disappointed.

But I also want to highlight the fact that PCPI has done their best and is not a multi-million dollar organization that just develops measures. They've done this for a long time and I think this is, to my second point, an opportunity for us to codify -- maybe with staff's help -- some of the things that came out of this because quite frankly this fits directly into our gaps discussion.

I think that we were talking up here, but this may, if you don't mind, give us some

grist for the mill, both from the standpoint of the challenges of performance measurement, but also highlighting the importance of appropriate funding levels to develop these measures in a way that is timely, that reflects current care, that is forward-looking in terms of the use of new technologies, yadda, yadda, yadda.

Because this isn't really, in my opinion, their fault. So we just want to thank you so much for being here and we appreciate it, and we hope that we can be collaborative with you about this, you know. As much as I know you're disappointed about the outcome for now, we are on your side. So we want to -- I want to say that on behalf of the Committee. So we thank you.

MS. CHAVARRIA: Thank you, and I will hold my tears for when I'm outside.

(Laughter.)

CO-CHAIR CASEY: Okay.

MS. CHAVARRIA: No, no, but thank you. It's been -- thank you for your time. The feedback -- again, very thoughtful feedback, very

useful feedback that we will certainly take back with us.

CO-CHAIR CASEY: My problem is they all live in Chicago and they know where I live so, you know, it's like -- they're coming to get me.

(Laughter.)

CO-CHAIR CASEY: So, thank you. You can stay as long as you like, but I understand this. Let me ask at this point, because we did get started -- and I think we made good progress on the gaps discussion, and I know Gerri was very intentional with me last night in being sure we had enough time here.

Let me take a pause and ask Peg if we're tired, whether we could sort of take a break. I don't mean in five minutes. I mean for a few days and maybe have an opportunity once we've brought some of this stuff that's written down back together to have another discussion about it, knowing that you'll do your homework too on the preferred practices as well if you

haven't, right?

MS. NACION: So we do have a post-comment call. I know we'll have that and we will -- we can continue it on that call. We'll also do relating and competing. We'll have to look at the measures, because some of the measures that are in that list are maybe not going to be measures endorsed anyway, so we'll have to see how that goes.

But I think we can if people feel they're ready to leave. We have a few housekeeping things. We have to open it for public comment, and we have to do next steps.

CO-CHAIR CASEY: Yes.

MS. NACION: But if people want to -- I don't want to -- you know.

CO-CHAIR CASEY: Well, why don't we do this? Let's do public comment. We can do next steps, and let me ask each individual that wishes to stay to maybe after we've done that, spend a minute or two just reflecting from their own perspective on what we did well and what we could

do better. I don't just mean working as a group, because I think we did that well, but in terms of our thinking, okay? Would that work? Yes.

MS. NACION: So Yetunde's just coming around to discuss the standing committee terms.

MS. OGUNGBEMI: Oh yeah. Please don't leave yet.

MS. NACION: So don't leave yet.

CO-CHAIR CASEY: Right, right. We're not dismissing you. We're just saying if you have to -- if you have to go, you have to go. But we finished early at least there. Let me ask Katy to -- and the operator to see if there is anyone on the line that wishes to make public comment at this time.

OPERATOR: At this time if you would like to make a comment, please press star and then the number one.

(No response.)

OPERATOR: There are no public comments from the phone line.

CO-CHAIR CASEY: Okay. So thank you

operator, and we want to keep our members on the phone too, if we can, to listen, so -- for next steps. But before we do that, I've been asked to go around the room and ask each of you to read your term limit.

MS. OGUNGBEMI: Yes. Please say your name first and then read your term limit.

(Off microphone comments.)

CO-CHAIR CASEY: Anyone else?

MEMBER WIEFERICH: Must be me. Jeff Wieferich, two years.

MEMBER BECKWITH: Samira Beckwith, three years.

MS. OGUNGBEMI: Thank you. There were an even number of both, so you picked them. Thank you all.

CO-CHAIR CASEY: What else do we need to talk about from a housekeeping standpoint, Peg?

MS. TERRY: Just next steps.

CO-CHAIR CASEY: Next steps, me and Katy?

MS. NACION: So I'm just going to briefly go over the next steps. These are our upcoming activities. We will have a post-meeting call on March 7th, and the draft report will be posted for public comment on March 30th.

And if you do need to get a hold of us for any reason, any questions or comments, please feel free to email or call us. These are our contact information. We also have the project page here, as well as the Sharepoint site. That's it.

CO-CHAIR CASEY: Well let me ask, because I think the public comment will be just about the measures, am I right? They will not comment on the gaps. That's our own internal discussion. Am I right or does that -- am I wrong?

DR. TERRY: Well, it will be what we need to finish. So we could do related and competing, you know. We could do anything.

(Off microphone comment.)

DR. TERRY: Oh right, right.

CO-CHAIR CASEY: So gaps needs to be in the report, and could you put that back up May, about the time line? So post-meeting call would probably -- it's two hours. It looks like what -- what would we do during that? It would be just going through the seven measures to recap where we are? Would we be doing any specific work before that or during that?

DR. TERRY: So there are some information we're waiting for possibly from Larry Kleinman and maybe --

CO-CHAIR CASEY: Right.

DR. TERRY: Yeah. So there may be that information coming in, and so we'll discuss that, and the other issue is related --

CO-CHAIR CASEY: So in other words anything that comes in, and then you're going to do the -- we have the related measures listed out or not?

DR. TERRY: We do, we do. Some of them may -- yeah. We'll talk. Some of them may not be existing measures in the future, but yes,

they still are related today.

CO-CHAIR CASEY: Okay. So I would suggest for the benefit of the -- and I'm sure you're doing this, but just whenever you get information that you think is useful to us, send it out to us so we can work on it.

DR. TERRY: Absolutely.

CO-CHAIR CASEY: And then the question about gaps, knowing that there would still be time before the public comment.

My suspicion is Gerri and Rich, you help me out. I'm wondering about how or if we should have another conversation about gaps after we've allowed the dust to settle on the day. I don't mean to make this a long drawn-out thing, but is that in scope?

DR. TERRY: Well, I think we can do it. I'm not sure exactly what you mean, but I think we can look at that. It's part of what we're doing. It's important that we look at the future and where you're going, and I know you've started that, in that off cycle work so it's a

good --

CO-CHAIR CASEY: So we could get some insights from today. You can synthesize that.

DR. TERRY: Right, right.

CO-CHAIR CASEY: And we'll probably have a few more insights from our roundtable, and then we can look at that and say yay or nay, we want to talk through it, right? Yes Ellen.

MEMBER SCHULTZ: I just wonder whether there might be some sort of synergy with the Measure Incubator effort that NQF has going on. You know, there hasn't been a convening of that group in a little while.

So, you know, maybe that's something where this Committee has something to share, be it highlighting some gaps or some, you know, thought experiments or whatever that we would want to engage a broader community of measure developers that are looking for guidance and also looking for help.

How did they overcome some of the barriers that we've talked about here, where we

want to get to that next level of measures but, you know, the data's over here and the challenges of testing are over here. So that might be another place where we could engage.

CO-CHAIR CASEY: Yeah. It's a good point and I wonder if the comments Gerri and I sort of made to Dr. Agrawal this morning is apropos to this too, which is this is, as we've identified, Brenda, you know, started it, that this is a high stakes issue and we really feel like we don't -- we're not there yet and we need to get it right.

So the question is, and Rich you're in the high place, do we elevate this to a point where it's part of a pretty direct conversation with the incoming administration about what we can do better.

I mean I think we've done a great job, but obviously, no offense, the measure developers are still back here trying to sweep things up and don't put that down on the record, but I think you all know. So what do you think Rich?

MEMBER ANTONELLI: So Ellen, I don't think that I've ever heard you say anything that I don't resoundingly agree with. So in fact we just got pinged from the incubator. So there's been a series of requests coming out from the incubator to folks that are actually doing some work in this arena.

So I think one of the things that we could ask of the NQF staff is really, and I'm not going to misuse this word, "coordinate" across all the various activities within the NQF itself. So when we're agonizing over a measure that the spirit is right but the implementation really feels like it's falling short, it would be great to know that there's something in the pipeline.

I think that will give us some clarity when we're thinking about harmonization or parsimony or, you know. I'm going to vote for this even though it sucks kind of thing. But you know, let's give it six months and then --

So I think that kind of transparency within NQF is really important. I am anxious

about that point that you raised about conversations with the incoming administration. We should all be very mindful that the NQF has contracts with CMS, and I've had two conversations at meetings that CMS staff have called, and in those meetings I said so I have a question and they said we can't answer it.

So we are in a period now where I think we need to invoke the Irish Serenity prayer. The things that this group can control could at least be conversations within NQF, and then we can be mindful about what we go outside. But again Ellen, I think the observation about what's in the incubator and what are they soliciting will probably really whet a lot of people's appetites around this table, because frankly some of the stuff that I've seen is kind of moving across that bridge that you pointed out this morning.

CO-CHAIR CASEY: And you know, you've always agreed with me but you've never quite asked me what I think of the Patriots, the Red

Sox, the Bruins. So don't do that, okay. Elisa.

MS. MUNTHALI: Thank you so much for your comments. This is something we have been talking about and have started to do through part of what Marcia talked about before, the feedback loop. You didn't see it earlier, but intentionally our colleagues from the incubator were here to hear your gaps discussion.

That is because we do recognize that we do need to inform each other, upstream, downstream, so that we're linked better internally.

CO-CHAIR CASEY: So Ellen, thank you for bringing that up. That's a really, really good idea. Why don't we just go around the horn. We started over here, so let's start over here with Samira, and tell us what worked and what didn't and, you know, you can say the food was great and, you know, the diet title like diet ginger ale, or you can say, you know, I wish we had done this or that. So give me your thoughts.

MEMBER BECKWITH: Yeah. Well, I

thought that two calls that we had prior to the meeting were very helpful, and I don't know that much more could have been done before this meeting. But I feel much better educated after this first meeting. So I thought everything was very, very helpful, and I look forward to the future.

CO-CHAIR CASEY: It's kind of like swimming for the first time, right.

MEMBER BECKWITH: Yeah.

CO-CHAIR CASEY: You can watch the video all you want, but until you're thrown in the pool --

MEMBER BECKWITH: Exactly, that's good.

CO-CHAIR CASEY: But we don't let anyone, you know, well I didn't say that.

MEMBER BECKWITH: Well --

CO-CHAIR CASEY: Get their hair wet, how's that? Jeff.

MEMBER WIEFERICH: For me, just I have a much better understanding about what the

Committee does, what the purpose is and, you know, getting to go first and not really knowing what to talk about is fun, so I appreciate that.

CO-CHAIR CASEY: Well, we didn't even -- we thought you were an expert. I mean it didn't, you know.

MEMBER WIEFERICH: You're a little kind, but thank you.

CO-CHAIR CASEY: No. You did very well. I mean it's like, you know, you show up and you do the work, and that's it.

MEMBER WIEFERICH: Makes me appreciate even more all of the work the staff does, because without the staff and all the stuff that they did, this would have been impossible really. The volume of information for each of these measures is overwhelming. So thank you to the NQF staff. That worked really well.

And I was just thinking how the phone calls actually worked well as well, I think. And to a certain extent I think we made many of our decisions already at the phone call level, and

this was more of a ratification of it. It's nice to hear the further fine points of justification.

I don't have a good sense of how many votes were swayed, based on the conversation today that we're a step firmly established on the phone calls. So that might be something to look into, you know, more phone calls.

CO-CHAIR CASEY: Well, I think the staff is always trying to take the temperature of the group, you know, just in terms of is this going to be, you know, you've done these -- I forget what they call them, where you put everyone in the room, modified Delphi, where you know, you end up with two and one, two, three, you know, it goes all the way across to nine.

They're looking for, you know, that type of situation. But I think most of the time we land in pretty much the same place. We got close on a couple of things, but I think it just helps set the tone for the meeting. So thank you.

MEMBER WIEFERICH: And just one last comment on sort of gaps, because I'm not sure

you're going to make it around again. That's to look at, as we talk about care coordination across the continuum, in fact we had to expand it out to folks that are not eligible providers; we even need to get into the community and beyond even.

There's a similar issue around interoperability. So I'm on the interoperability work group, and then -- and really the challenge is how can you -- how can you create interoperability measures that actually drive the adoption of interoperability, and sort of what is it, how much interoperability is sufficient for where you are in this continuum, because if you're down in the home and community-based service realm, your interoperability may be very well served by fax and PDFs if you want.

But if you're a big network with an integrated EHR, then your interoperability is huge and very complex. So that to find a measure that meets all of those needs I think is going to be a challenge, but the important thing is that

we need to align interoperability measures with what we're doing here around care coordination, because care coordination extends to places that interoperability doesn't, and I think the two have to go together for this to work.

CO-CHAIR CASEY: Yeah, and if you remember, I don't know if you recall, in the preferred practices we actually talk about that. We don't use the term "interoperability," but we describe what we mean by that in real terms, and we also aspire to having one plan of care, not 20 so --

MEMBER ANTONELLI: So in my training and residency in the neonatal ICU I always thanked the nurses. So the equivalent is to always thank and acknowledge the NQF staff. You guys are absolutely amazing.

(Applause.)

MEMBER ANTONELLI: The volume of information, the number of moving parts and putting it together in an elegant way that allows us old people to figure it out. I thank you from

truly the bottom of the my heart. That was great. But this is the first time I'm ever going to say this, but that -- and it was inspired by your comment in the hall.

I hope the newbies didn't slow things down, and I want to take that head on because to the contrary, every single new person here, talk about hitting the ground running. It was just, you know, I think your analyses were great, the questions were insightful, and frankly Don I think from my perspective bringing this new blood in here and the two people that I know the most from outside of this are those two people over there.

This is exactly the kind of voice that we have to bring into this. So and then I kind of want to end with a sobering comment. I feel like this group and others, but this group in particular, we have I think an obligation to inform the field of care coordination and care integration. I'm going to keep using those two terms.

What do I mean by that? It's painful to sit through a measure that you know isn't going to measure up, but somebody's put a lot of work into that. I won't tell you which one, but at the steering committee last month, when the resist flag was being hung outside that window, just saying, somebody had put like two years of work into a measure and not a single person around the steering committee said right on.

In fact, we thought that it was kind of misconceived, and that's a hard message to deliver. Not because it wasn't a good measure, but it wasn't really directionally where we want. So I actually would put some pressure on us to let -- the sooner we can do that internal analysis of existing measures, and I'll look to the NQF staff, the more interconnected we can be within the NQF's walls to know what's in that pipeline, the sooner we can start pushing things out.

In an ideal world, PCPI would have come in today and say we're going to withdraw

these measures, because we've got a new one, or we've adopted -- we've adapted that one to measures such as us because you guys gave us the direction. So yes I'm challenging us. But I think to the degree that the NQF has this august position to inform the field, we need to do that.

I would argue that it should be a performance measure for the standing committee as to the number of measures that we evaluate that are directionally appropriate. I hope that people can consider that the polite challenge that it's intended to be.

CO-CHAIR CASEY: So taken. Emma.

MEMBER KOPLEFF: I really enjoyed being with you all today and having some great brains in the room. I think the fact that we were so thoughtful in not accepting, even though we trust and value our predecessors on this Committee's judgement, it's a testament to where performance measurement has gone and this group.

So even though sometimes it feels like a snail's pace in terms of the types of measures

we're getting in front of us and that metric that you speak to, to me it was heartening that we were able to take a critical look and a thoughtful look at not just what's up to snuff and what's not, but how do we make it better.

I thought just the spirit of this group and thanks to the staff and our co-chairs for supporting that was very collaborative, congenital, good sharing of ideas and information and that can be a challenge when you throw people together.

I appreciate the in-person look at you all. While I agree the pre-work over the phone was a good start, I think there could be some efficiencies there in terms -- I think the most valuable -- for me the most valuable takeaway I got from the phone calls was more the direct questions for the developers, so the developers could come in ready to respond to those, in terms of reviewing all the measure specs and everything like that.

I mean it's hard work and this group

has shown they're dedicated. It's hard to do it as a group, you know, and staff has supported us and urging us to do our homework so --

CO-CHAIR CASEY: Well, and just be mindful of the fact that that doesn't occur in the context of public scrutiny, whereas this meeting does.

MEMBER KOPLEFF: That's true.

CO-CHAIR CASEY: So we do have to step through that. By the way, after you walk out the door, there will -- none of you will be newbies, so you know, get over that. It's gone.

MEMBER KOPLEFF: And I apologize for leaving early but I've got a kid with a fever.

CO-CHAIR CASEY: Thank you. Thank you very much. Brenda.

(Off mic comment.)

MEMBER LEATH: I just want to say that it's been honor to be on this standing committee, and to have an opportunity to work with everyone around something that's so very, very important. I really meant it when I said that care

coordination is an area that ultimately gets pushed aside, doesn't get the -- its just due.

So I am happy that an organization such as NQF is embracing a focus and dedicating resources and commitment and time toward trying to develop measures in this area. I think one of the gaps, if we're going to look at the engagement of community-based care coordinating agencies and organizations in this process, I think many of them will need certain kinds of tools, and I think Rich that's what you were alluding to.

That's going to be very critical if you want their input, in helping to develop measures that might be meaningful for their operations. And you know, lastly I just want to compliment the staff on all the preparatory activities and the organization of all the meetings that we've had, because it is very impressive to get all of the information distilled and, you know, in a format that one could readily review and begin to cogitate on it.

I guess I do have one last thing, and I want to say that I like the dynamics of this group because everybody's been very receptive to very different viewpoints. I think that that's critical as we try to move forward. So thank you.

CO-CHAIR CASEY: Godmother.

MEMBER MICHAEL: Sure. I'm going to be very brief. I think that the staff and the prep work were great. The sharing of ideas is great. My only wish is that sometimes we get down tangents, and I think we need to come back a little quicker, because we do have a lot of work to do. We need to evaluate more measures, I think. As Terry or Rich was saying, we need to be able to get through more of them and we need to really use this time for that. But it's been a great experience.

CO-CHAIR CASEY: Thank you, Karen. Ryan.

MEMBER COLLER: I appreciate that I wasn't quarantined, and apologize for all the Kleenex I went through. I was going to steal a

box off the front desk, but anyway I wanted to echo the thanks and appreciation to the staff. I felt like the meeting and the prep work was very streamlined. Not only that, but the process is pretty transparent and somebody can sort of fold into it and try to follow the algorithms and approach measure assessment in a way that's consistent, and take away some of the potential subjectivity and make evaluations as objective as possible.

So I think that that's a great testament to the process in the way it's been developed over time. Don, I really appreciated your level-setting at the beginning, because I think I did really struggle with feeling some level of, you know, hope that we would be able to get to a higher level of measurement than we can right now with where we're at, and I think you did a nice job of sort of helping calibrate us to where the current state of the measurement is, and it allowed me to be a little bit less hard, I think, on some of the measures than I sort of

felt like coming in otherwise.

I wanted to mention a couple of other things. I personally feel like -- I was wrestling with the tension between while I was reviewing measures, approaching it like a peer reviewer and wanting to make a bunch of constructive feedback to the measure developers, versus just an assessment black and white, here's kind of where things are at.

I don't know if that feeling represents an opportunity to have more dialogue with measure developers, so that folks like, you know, the second half of the day maybe could come in and I don't know if they felt surprised by the result or not but try to mitigate some of that.

And so that was just one sort of reflection I had. Lastly, I'm very energized by the work that the group is going to be doing outside of the measure voting process that we did today really to the gaps in care coordination. I think that to keep ourselves sort of at the cutting edge and avoid becoming, you know, more

stale because of the current state of where our data streams are and where the state of current care coordination measures are, thinking about how we can create a vision for the future of care coordination measurements.

I'm very energized by being able to be a part of that with this group, and I think that that will do all of us good for the field.

CO-CHAIR CASEY: Well let me just highlight one thing you said, because I think each member of the Committee still has the ability, either directly or through whatever organization they're involved with, to participate in the public comment and give that type of feedback.

So but here obviously we're doing the business of, you know, getting the measure endorsement process through the hoops, and it's a challenge in the beginning, but thank you. Ellen.

MEMBER BECKWITH: Sure. So thinking a little bit more broadly about measurement and a

lot of conversations in recent years about having too many of the wrong kinds of measures. I know NQF has recognized that and called it out in part of our strategic plan. How do we reduce the number of measures and get closer to measuring what matters?

So I wrote down a note to myself at the beginning of the day, which was the question that if we keep using the same process and the same criteria to evaluate measures, can we really expect to get a different outcome? Can we expect to get something other than 700 measures, a lot of which are on process, on particular disease conditions or care settings, sort of a stream of minutiae.

But I'm really rethinking that after today, because we had, you know, even using the same process and the same criteria, we had a really rich discussion, and we had a lot of challenging going on in the room and yet we did it in a way I think that was positive and constructive to developers.

And we did get a different result, all right. We have a lot of measures that are coming up for maintenance review that didn't pass, you know. Whether that's good or bad on an individual measure, it's different from what I expected even going through the same process. So it's food for thought, I think, that for NQF, from a bigger picture thinking about how you go forward, how do you keep pushing the field and measurement forward as a whole, you know.

Where do you need to work within that existing process, and where is there room where some changes need to happen to processing criteria? We heard a lot in the room today repeatedly about bringing in the patient and the family voice. I believe really strongly in that, and I think one really important way that that could happen is bringing them in to some of those big picture thinking about the process and about the criteria.

That had a huge ripple effect across a lot of different areas, and maybe care

coordination is a place to pilot that a little bit.

CO-CHAIR CASEY: And you're starting hard on the preferred practices, right?

MEMBER BECKWITH: Yes.

CO-CHAIR CASEY: Good, thank you. Chris.

MEMBER DEZII: Yeah. I guess it's sort of like having a patient say what are you people doing here, right? The NQF incubator, I think, would be a nice vehicle. It was nice that they were here for the gaps. But I don't know if they operate via an RFP process, or at least identify areas like care coordination as areas for folks to submit, you know, measure ideas, with a nice template and following the template.

I don't think anybody did a grading of the evidence, and I think our dialogue can understand why nobody graded the evidence. I think they should. What else do I have? My tolerance threshold was tightened a little bit today and that's cool. You know, I came in

looking -- you know, I really do believe in that bridge and you know, but this was -- this was too hard to overcome, some of these challenges.

I had a technical challenge with the -- I didn't realize my work group wasn't going to be here, and I had a technical challenge in that I really didn't know what their comments were until ten minutes before I started speaking thanks to Katy, because I couldn't access the stuff. So if I appeared to tap dance, that's what I was doing.

So thanks for bearing with me. That's all. Ryan, we better advise the measure developers, okay. I think that's part of what I think our job should be. Those are my bullets.

CO-CHAIR CASEY: Great.

MEMBER ANTONELLI: Don, I apologize. I have to jump in here because I understand what you mean by peer review. Maybe you guys should speak to that, because I think there -- considering that we're sitting in a position of judgment, it's a little bit different to advise

and then potentially have to be in a position of saying okay, this measure reflects input that I gave the developers six months ago.

So there could be some muddy waters in there or maybe I'm wrong. But I guess I just can't let this piece lie without it being openly discussed, because this isn't a peer review process.

CO-CHAIR CASEY: You want me to answer that?

(Off mic comment.)

CO-CHAIR CASEY: Well let me get to the rest of the group, and then I'll address that, okay. I'll try to. Charissa.

MEMBER PACELLA: So I was not exactly sure what to expect, but it was a great day with lots of smart people in different places. I look forward to the idea of having care coordination measures that span spectrums and are very patient-centered. It's a huge challenge to come up with those things and I think they're, you know, driving new things.

I was just a little bit disappointed not to be able to love anything, you know. It's right there, and then my only other thing is could preferred practice somewhere, could somebody tell us like exactly where it is or put the link in an email, because that would really help.

And then I mean I have lots more thoughts about care coordination that should include people like radiologists with findings in addition to patients and everybody else, and just areas we haven't even really gone to very much, and that's it. I hope there's a way for the measure developers to get some additional feedback prior to a day like today, even if it's not from within this group.

CO-CHAIR CASEY: So Charissa, let me help the staff, because I think some of them may not know this perfectly well, but there's sort of two documents. One is the original preferred practices, which I think came out in a tome about 2010, and then probably in '14 I think in a slide

set or some sort of white paper we sort of upgraded.

I would recommend you read both, because you can see how that's evolved, and I certainly think these I hope will continue to evolve, because I do think it sets the stage for things like peer review, which I'll address in a moment. But Shari.

MEMBER ERICKSON: Well thanks. I'm really just very honored to be able to participate in this, and I appreciate it on a variety of levels as, you know, in my day job as well as an individual who has coordinated care for my family members, and just in terms of personal interest and coming from my background from being at NQF as a staff member.

So I do sincerely appreciate all the work the staff has done, and I have staffed committees at IWIN (phonetic) before that, before I came here and then here and now at ACP. So I get and empathize with all of the work that you go through and appreciate that.

A couple of things I just wanted to pick up on, and you know, Ellen, everything you said just really resonates with me and I have to say I couldn't agree more, that the patients need to be engaged and however NQF can figure out how to do that. I know we're trying to do that more at ACP in our work.

We have certification partnership now. We do have patients that are on our clinical guidelines committee now, and I know we're trying to think through how to do that more with our performance measurement committee as well. So I just -- I strongly encourage that we try to figure out how to do that, because I think it would really --

It's hard though. I don't have to go down a whole soliloquy on that, but it is challenging for a variety of reasons. Okay.

(Off mic comment.)

MEMBER ERICKSON: Okay, great, great. The other thing, you know, because I do -- I guess part of my reasoning for going into this is

I do think as someone who's watched this quality movement for a while now, you know, care coordination measures and measures that get at patient-reported outcomes and experience, moving beyond, although I recognize the value in the CAHPS survey, has just got to be the way of the future, I mean really.

And to the extent that NQF can push the field in that direction, I think that would be helpful. Just related to today, I feel really good about where we landed. I know -- I didn't really expect us to land in a place of saying, of voting down some of these measures either, and I think -- and I feel kind of bad about that in a way in terms of the measure developers perhaps being surprised by that as well.

But I think, you know, and I hear about it from our members in terms of the measures that they're asked to report on or their entities are asked to report on, you know, these are things that would drive them crazy and wouldn't get them to the place where they want to

be. And so, you know, I think we landed in the right place, as challenging as it might be, and I agree with you, the process landed us there in a way that I wasn't expecting.

You know, I do think informing the field, that you brought up Rich, is really important and moving that forward. Part of it, you know, coming from a specialty society in medicine, you know, ACP has been a pretty strong supporter of NQF and the process for really since its inception.

But we're not -- we're a minority in many ways these days among the medical specialists, specialty societies. We don't develop measures so perhaps that's why we are there. But you know, a lot of other societies have been really frustrated by the process, because as we were talking about, you go through years of development and only to have it sort of shot down, so to speak, in the committee process.

I know that NQF has made a lot of improvements in the process, which I think are

fantastic in trying to move forward and the incubator and all of that, and just you know, I think continuing in that direction is the way to go. But you know, there's still a ways to go there because it does concern me that, you know, we could have measures just go, landing in reporting programs that really haven't had an external entity really look at the evidence and review it from a multi-stakeholder perspective. It is inclusive ideally of the on-the-ground users of the measures and the patients and families too so --

CO-CHAIR CASEY: Well and you do generate guidelines, which is the foundation for performance measures, and so you're --

MEMBER ERICKSON: Yes, yeah.

CO-CHAIR CASEY: Barbara, we're going around the room talking about what went well, what we liked, what we had to wish we'd hoped for that we didn't achieve. I'll let you think about that for a moment, because I want members of the staff to weigh in to with some of their thoughts.

So Peg, you had something you wanted to say.

DR. TERRY: Well, I just really wanted to thank everybody for your participation today and your engagement. It's really been a very, I think a good day and a lot of good discussion. In particular, I want to thank our co-chairs, for Don and Gerri, for all their work and we work with them offline and there's a lot of work, you know, that's happened before the meeting and more to come. So again, thank you all for today and the work.

MS. MUNTHALI: I just wanted to echo what Peg said. It's a lot of work for staff, but we know it's a lot of work for you, and you have other jobs and we just really appreciate all the time and effort you put into this work. So we can't thank you enough.

I just wanted to thank our team as well, and going back to we're noting all of the comments. We really appreciate the feedback. We received quite a bit of feedback and criticism about, you know, developers' inability to come to

us early, enough for us to give feedback.

Something we did institute a few years ago is technical assistance, which a lot of developers and committee members and others that are engaged in our process are not quite aware of it, and it's part of our communication challenge, to let them know. As I was talking to PCPI here, I said you know, it would be great if you guys came to us first. We cannot guarantee a pass by the Committee, but we can tell you the likelihood of something going forward or not based on our criteria.

And so they, you know, they will come to us early. The other thing is, you know, trying to get the patient voice around our tables. It is difficult. As you can tell, the information is very dense. It is dense for many people, clinicians, those that are methodologists, those that work in measurement. It's a lot of information.

It is another communication challenge, education challenge. We're trying to work on how

do we get the right voices, the mix of voices around the table? So this is a commitment we do have. We are working with CMS as well to, you know, make sure we know that the challenges are there with MIPS and MACRA, and there are some requirements that don't have to -- for measures that don't have to come to NQF.

That means that, you know, they may not go through a multi-stakeholder review to review the evidence or the testing. CMS recognizes that it is an issue. We are in constant communication and discussions about, you know, what is the viable path forward.

So these are things that we are discussing, trying to work on. We'll be in touch with you throughout the process, but we just wanted to thank you for your thoughtfulness.

CO-CHAIR CASEY: Thank you, Elisa. Dawn, are you still with us?

(No response.)

CO-CHAIR CASEY: Dawn was on the phone. Are you muted, Dawn? We don't have

Lorna, and I think Marcia was just on for a short while. So before I turn to Barbara, let me ask the rest of our team if you want to make any pronouncements about how you thought things went.

Again, you did a great job and we really appreciate it, and as I told the newbies to care coordination, it's when you work at NQF and you now become staff for the Care Coordination Standing Committee, that's a big rite of passage within NQF. So you've made it. You're cool. Barbara, do you want to --

MEMBER GAGE: I'm sure it's already been said, but the materials that you guys prepare are very helpful. I've been on the other side with the me measure development and it's a pain to put the submission materials together. But you guys really brought things down to -- in a nice summative level and included the resources we needed to look further into the details. So thank you.

CO-CHAIR CASEY: Karen, do you want to chime in? You're sitting back there. You're

always great to have in the room with us, especially when we get stuck on things. But you want to say anything?

(Pause.)

MS. JOHNSON: I was just going to say I've been here a little over five years now. Care coordination was my first project here, and some of you I remember from five years ago. But most of you I think are new since that time. So it's been really interesting.

I'm kind of going back in my mind from what I heard today compared to what we did back in 2012. So it's really interesting to see the progression and the evolution of the committee itself, as well as, you know, just measurement science in general. So thanks for letting me listen in.

CO-CHAIR CASEY: Thanks, and our friend in the back, our audiovisual expert, you've got everything down, right? So thank you very much. Let me have a few quick comments.

One is I do think today, and Karen you

can back me up on this, was further evidence that NQF's hard work to bring to bear the importance of science in the measure development process is really paying off, and I know it's been a journey from where we started, and I won't say anything pejorative.

But it is now rigorous. I'm not saying anything pejorative about the way it was done in the past, but it's rigorous in the right way and it requires us to really think hard about the application of evidence, and I always say there are two levels of evidence to a measure.

One is the evidence supporting the use of the measure and the rationale, and I think the next phase of this is, along with what Brenda was talking about, which is when you say measures that matter, prove it. Prove it that they did matter, that there was an impact, that lives got better by the use of the measure.

I think that's kind of the next phase of where we're always trying to go. It's kind of like the Mount Everest of where we need to be.

That's a challenge, as we know, for things that don't have big randomized control trials like the use of ACE inhibitors for heart failure that reduce morbidity and mortality.

So I applaud NQF for really staying the course in a very complex environment to get this forward. I also think that the measure -- and again, I don't want to dwell in specifics here, but I will say that it used to be, relatively speaking, less challenging to be a measure developer, and Barbara I think you'll agree with me.

Measure development should really be much more of a team sport. I always say when people say there's not enough money, I mean I say wait a minute. You've got the providers over here; you've got the health systems here; you've got the IT vendors here and you've got the insureds here, and you're saying we can't work together to get it right?

So that's a big aspirational, but it seems as though just asking groups who are

resource-constrained to keep trying to do the same thing is a fool's errand without them being at the table. They're extremely talented people and I know they're trying. But it seems as though we have to push the envelope, though, on this being a high stakes opportunity to change the game, so to speak.

I think this conversation just adds to the thinking about why that's important. I think, you know, I apologize for not being on the two calls. But the thing I would have liked more of would have been just to hang out with you, because I always find that through these committee meetings, getting to know people over time it's been a lot of fun.

You know, we get to know each other in the meetings, but I think -- and it's hard, because some people come in the day of and leave. But I just look forward to working more with you and getting to know you better, and I appreciate the chance to be the chair.

I know Gerri would probably say the

same exact things that I would say. She's a real fantastic person and I'm really always in awe of having her around. So I'm going to speak a little bit for her and say that she and I both agree that this was a great, a great new phase and we look forward to working hard together.

So that's it. Did we miss anything?

FEMALE PARTICIPANT: I don't think so. Thank you.

CO-CHAIR CASEY: Okay. Thank you.

FEMALE PARTICIPANT: Thank you.

CO-CHAIR CASEY: Thank you very much, great.

(Whereupon, the above-entitled matter went off the record at 4:50 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Care Coordination Standing Committee

Before: NQF

Date: 02-22-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter