

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 COLLIER, 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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1 P-R-O-C-E-E-D-I-N-G-S

2 8:41 a.m.

3 DR. TERRY: Good morning, everybody.

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

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

20 (Laughter.)

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

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

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

19 (Laughter.)

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

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

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

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

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

11 DR. TERRY: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 CO-CHAIR LAMB: Thank you.

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

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

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

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

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

22 So, that's an initial screening. So,

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

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

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

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

1 but we are particularly interested in those
2 items.

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

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

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

22 So, your Co-Chairs have already done

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

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

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

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

1 have no conflicts to disclose.

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

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

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

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

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

7 MEMBER COLLIER: I'm Ryan Collier with
8 the University of Wisconsin. And I apologize for
9 any sniffing or coughing, I caught my youngest
10 daughter's cold and pretty much the cold of every
11 patient I've taken care of for the last week.

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

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

1 forward to becoming a part of the journey.

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

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

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

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

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

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

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

21 (Laughter.)

22 MEMBER ANTONELLI: Except possibly

1 Terry.

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

5 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

16 MS. HAMMERSMITH: Okay, thank you.

17 Marcia James? Is Marcia James on the line?

18 Lorna Lynn? Is Lorna Lynn on the line?

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

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

1 anybody else on the phone I've missed?

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

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

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

8 MS. HAMMERSMITH: A little bit.

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

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

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

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

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

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

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

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

20 MS. HAMMERSMITH: Actually --

21 CO-CHAIR CASEY: Or is it the
22 Committee?

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

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

13 CO-CHAIR CASEY: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 So, in 2006, okay, remember we're in
15 2017 now, there was the initial model development
16 and an initial definition of care coordination.
17 And if you move forward, that definition has been
18 added to, refined as we've gone along. So, 2006
19 was the initial model and definition. I believe
20 Don was part of that work, I was not. Anybody
21 else in that 2006 group? Rich was, okay. So, we
22 have historians in the group.

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

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

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

1 look at the connects in the system?

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

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

16 So, we're fast-forwarding, then, to
17 2014, where there was a Measure Gaps Committee.
18 NQF really has put a lot of emphasis and
19 resource, and I would just like to echo Don's
20 comment, is Helen has been through all of that
21 with this Committee, in terms of assisting us to
22 move forward in terms of measure gaps and really

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

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

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

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

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

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

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

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

1 turn it over to Don to take it to today.

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

6 CO-CHAIR LAMB: That was fast.

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

8 (Laughter.)

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

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

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

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

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

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

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

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

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

22 And I would say most of the measures

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

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

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

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

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

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

8 MS. STREETER: And Lorna.

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

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

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

18 CO-CHAIR LAMB: Okay.

19 DR. TERRY: So, Katie?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 or provide an advance care plan.

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

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

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

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

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

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

1 us your thoughts and impressions.

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

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

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

1 patients.

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

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

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

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

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

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

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

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

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

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

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

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

22 The information submitted, there was

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

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

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

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

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

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

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

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

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

8 Another comment regarding that was,
9 there's no standard definition of the necessary
10 components of advance care planning. And the
11 baseline, follow-on measures were from 2012 and
12 2014, which occurred before the CPT codes that
13 were mentioned earlier. I'm going to stop there.
14 Hopefully I'm going in the right manner that you
15 need.

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

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

22 CO-CHAIR CASEY: Right.

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

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

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

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

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

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

21 MEMBER BECKWITH: Yes, when we come to
22 vote.

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

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

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

14 MEMBER WIEFERICH: And I'll second
15 that.

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

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

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

8 MEMBER WIEFERICH: Yes.

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

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

16 They had 3,309 eligible professional
17 continuously reported performance rates from 2012
18 to 2014 and it showed an improvement rate of four
19 percent from 2012 to 2014, from 62.3 percent in
20 2012 to 67.2 percent in 2014.

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

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

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

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

1 the criteria.

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

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

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

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

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

5 CO-CHAIR LAMB: Any comments from
6 Lorna?

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

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

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

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

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

7 CO-CHAIR LAMB: Any other comments?

8 Thanks, Ellen. If you would, just remember to
9 put your, yes, put your name plate up before you
10 talk? Terry?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 forward and balloted a personal advanced care
2 plan through HL7.

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

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

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

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

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

1 want to pick just on you.

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

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

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

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

21 MS. OGUNGBEMI: I can't vote.

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

1 it --

2 MS. OGUNGBEMI: I want to --

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

5 MS. OGUNGBEMI: Yes, sir.

6 CO-CHAIR CASEY: I understand.

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

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

22 I will announce what we are voting on,

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

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

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

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

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

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

7 MS. OGUNGBEMI: So, usually, it's
8 easier, but I was trying to be clever this
9 morning. So, when you vote, it will be: 1, High;
10 2, Moderate; 3, Low; and 4, Insufficient, but
11 during the example, I made it a little tricky.

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

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

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

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

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

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

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

20 Okay. Voting results are: four High,
21 12 Moderate, one Low, and zero Insufficient; 24
22 percent High, 71 percent Moderate, 6 percent Low,

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

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

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

8 CO-CHAIR CASEY: Shari, before you --

9 MEMBER ERICKSON: Yes?

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

14 MEMBER ERICKSON: Okay.

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

17 MEMBER ERICKSON: Oh, okay.

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

20 MEMBER ERICKSON: Okay.

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

1 do that, but --

2 MEMBER ERICKSON: Right, sure.

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

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

8 CO-CHAIR CASEY: Right.

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

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

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

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

11 One comment, though, was that
12 reliability testing was based on a small sample
13 of records from only four sites, which raises
14 questions about generalizability across U.S.
15 population, however the reliability testing that
16 was performed showed strong reliability. And
17 others basically said, adequate testing from
18 2009. One other person said it wasn't clear.

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

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

4 MEMBER WIEFERICH: I have none right
5 now.

6 MEMBER ERICKSON: Lorna?

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

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

12 MS. STREETER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 DR. SANDBERG: Thanks for that
14 discussion.

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

22 MEMBER PACELLA: So, I apologize if I

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

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

15 MEMBER PACELLA: And, again, I --

16 MEMBER BECKWITH: -- excluding it --

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

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

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

9 CO-CHAIR CASEY: Okay, thank you.

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

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

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

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

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

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

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

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

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

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

1 somebody that didn't create it.

2 CO-CHAIR CASEY: Any other discussion?

3 This is great.

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

9 CO-CHAIR CASEY: No more discussion?

10 CO-CHAIR LAMB: Validity?

11 CO-CHAIR CASEY: Chris, go ahead.

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

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

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

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

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

20 CO-CHAIR CASEY: It's unchanged.

21 MEMBER ERICKSON: -- acceptable.

22 CO-CHAIR CASEY: Yes.

1 MEMBER ERICKSON: Okay.

2 CO-CHAIR CASEY: Good.

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

5 CO-CHAIR CASEY: We're good.

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

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

22 And so, this Committee, we can discuss

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

7 CO-CHAIR LAMB: Jeff, anything to add?

8 MEMBER WIEFERICH: Nothing right now.

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

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

15 CO-CHAIR LAMB: Threats are part of it.

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

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

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

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

1 excluded.

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

10 CO-CHAIR LAMB: Does Lorna have
11 anything?

12 MS. STREETER: Nothing to add.

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

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

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

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

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

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

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

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

22 CO-CHAIR CASEY: Well, we're hoping

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

3 (Laughter.)

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

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

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

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

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

11 (Laughter.)

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

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

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

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

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

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

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

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

3 CO-CHAIR CASEY: Shari, can I --

4 MEMBER ERICKSON: Yes.

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

7 MEMBER ERICKSON: Sorry.

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

10 MEMBER ERICKSON: Oh, sorry.

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

13 MEMBER ERICKSON: Okay.

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

16 MEMBER ERICKSON: Okay.

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

19 MEMBER ERICKSON: Okay.

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

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

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

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

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

22 And, unfortunately, there is no way to

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

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

12 CO-CHAIR CASEY: Terry?

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

22 So, I guess, for the Measure

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

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

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

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

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

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

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

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

13 MS. MUNTHALI: Yes.

14 DR. BARTON: -- I would agree.

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

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

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

3 MS. MUNTHALI: Correct.

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

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

9 CO-CHAIR CASEY: Rich?

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

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

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

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

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

5 (Laughter.)

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

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

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

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

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

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

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

1 MEMBER ERICKSON: Okay. We can --

2 CO-CHAIR CASEY: I think it is --

3 MEMBER ERICKSON: -- hold it to

4 Usability.

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

6 MEMBER ERICKSON: That's fine. I just

7 -- yes, okay.

8 CO-CHAIR CASEY: Yes. But I think it's

9 valid and so, why don't we -- any other points?

10 So, Shari, do you want to -- know that we've done

11 a parenthetical --

12 MEMBER ERICKSON: Hey, we've done a lot

13 of --

14 CO-CHAIR CASEY: -- on this.

15 MEMBER ERICKSON: So, I guess the

16 question is whether or not we feel, given this

17 discussion, there is a vote needed on the

18 Validity and the threats to Validity for this

19 measure, or do we accept the Validity data that

20 was presented previously? And I have to admit,

21 I'm torn, so I guess I could move one way or the

22 other and then we can vote. How do you process

1 wise want to handle that?

2 CO-CHAIR CASEY: Make a decision.

3 (Laughter.)

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

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

16 MEMBER ERICKSON: Yes, absolutely.
17 Yes.

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

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

8 MS. MUNTHALI: That would fail the
9 measure.

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

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

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

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

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

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

15 (Laughter.)

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

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

1 MEMBER COLLER: Can I --

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

4 MEMBER COLLER: Can I ask a quick
5 question that would, I think, affect my vote?
6 And I can invoke being a new Member and ignorance
7 for the question. The standard that we're
8 supposed to set for voting on Validity for this
9 measure is the same as if it was a new measure or
10 a Maintenance Measure, correct? I just wanted to
11 --

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

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

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

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

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

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

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

19 MEMBER O'MALLEY: Yes.

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

22 MEMBER O'MALLEY: Right.

1 CO-CHAIR CASEY: That's correct.

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

4 CO-CHAIR CASEY: Right.

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

7 CO-CHAIR CASEY: That's right.

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

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

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

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

1 looks like it passed the majority without our
2 people on the line. So, we will not vote again,
3 we will accept the previous vote on Validity and
4 move ahead. So, we're past our time here from
5 10:30, so we want to move this on.

6 CO-CHAIR LAMB: Feasibility?

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

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

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

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

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

10 MEMBER WIEFERICH: No, I'm good.

11 MEMBER ERICKSON: Lorna?

12 MS. STREETER: Nothing to add.

13 CO-CHAIR LAMB: Any discussion?

14 CO-CHAIR CASEY: Shari?

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

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

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

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

7 (Laughter.)

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

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

1 give it an easy pass.

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

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

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

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

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

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

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

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

22 But all the EHR vendors, the certified

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

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

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

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

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

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

6 MEMBER ERICKSON: Out?

7 DR. TERRY: -- easily. Right.

8 MEMBER ERICKSON: Or reported in?

9 DR. TERRY: Exactly.

10 MEMBER ERICKSON: Or both?

11 DR. TERRY: Out.

12 MEMBER ERICKSON: Okay.

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

16 MEMBER ERICKSON: Okay.

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

19 MEMBER ERICKSON: Okay.

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

1 MEMBER ERICKSON: Okay. And --

2 DR. TERRY: -- speaks to.

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

8 DR. TERRY: Yes.

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

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

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

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

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

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

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

1 it.

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

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

13 MEMBER ERICKSON: No, it's clinician.

14 CO-CHAIR CASEY: Clinician?

15 MEMBER ERICKSON: Yes. Well, qualified
16 clinician --

17 CO-CHAIR CASEY: Qualified clinician,
18 right.

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

21 CO-CHAIR CASEY: Right. Thank you.

22 MEMBER ERICKSON: Yes.

1 CO-CHAIR CASEY: Jeff?

2 MEMBER WIEFERICH: She covered it.

3 MS. STREETER: No comments from Lorna.

4 CO-CHAIR LAMB: Any comments? Barbara?

5 MEMBER GAGE: This is more a question.

6 There's a note about the MAP having noted a
7 couple years ago that for this measure to be used
8 in the ASCs that it would need to be modified.

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

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

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

1 And one of the comments that was in
2 the materials was that the MAP had pointed out in
3 2015 that the measure would need to be modified
4 to be applicable to the ambulatory surgery
5 centers. And so, I was just asking how much that
6 should affect our discussion of Usability?

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

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

15 DR. BURSTIN: The answer is, no.

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

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

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

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

17 MEMBER ANTONELLI: Yes.

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

20 MEMBER ANTONELLI: Okay.

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

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

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

9 MEMBER ANTONELLI: Yes.

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

13 MEMBER ANTONELLI: Got it.

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

16 MEMBER ANTONELLI: Got it. Okay.
17 Thank you.

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

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

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

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

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

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

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

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

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

22 And so, in that case, we're working

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

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

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

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

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

1 related to other NCQA programs and its use there.

2 So, I understand the patient-centered medical
3 home program has evolved and is released now sort
4 of in a new format that does have some credit
5 given, so to speak, for some of the measures that
6 physicians are, and I'm not going to get this
7 right, but that are reporting on, that they get
8 some credit, so to speak, in that program, to be
9 recognized as a medical home for the use of
10 certain measures and the reporting on certain
11 measures.

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

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

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

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

11 MEMBER ERICKSON: Okay.

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

14 DR. BARTON: That's a great question.

15 CO-CHAIR CASEY: -- NCQA certification
16 criteria?

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

19 CO-CHAIR CASEY: Okay.

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

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

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

9 CO-CHAIR CASEY: For QPP?

10 MEMBER ERICKSON: -- of the Quality --

11 CO-CHAIR CASEY: Yes, right.

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

14 CO-CHAIR CASEY: Yes.

15 MEMBER ERICKSON: -- in the Quality
16 Payment Program.

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

19 MEMBER ERICKSON: Right.

20 CO-CHAIR CASEY: -- at this point.

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

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

3 CO-CHAIR CASEY: Barbara?

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

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

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

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

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

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

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

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

17 MS. OGUNGBEMI: One more.

18 CO-CHAIR LAMB: All right.

19 MS. OGUNGBEMI: Just one more.

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

22 MS. OGUNGBEMI: Yes. We are now voting

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

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

5 MS. OGUNGBEMI: Yes.

6 CO-CHAIR CASEY: For --

7 MS. MUNTHALI: The CSAC.

8 MS. OGUNGBEMI: Well, the CSAC.

9 CO-CHAIR CASEY: For the CSAC.

10 MS. OGUNGBEMI: Results are unanimous
11 -- 15 votes yes, zero votes no, 100 percent yes
12 votes. So, Measures 0326 is Overall Suitability
13 for Endorsement is recommended.

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

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

1 11:13 a.m.)

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

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

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

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

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

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

20 CO-CHAIR CASEY: Thank you.

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

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

5 CO-CHAIR CASEY: Congratulations.

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

9 (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 I think the concern during the last

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

5 DR. KLEINMAN: So one of the things --

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

8 DR. KLEINMAN: Got it.

9 CO-CHAIR CASEY: Thank you.

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

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

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

1 those who have identifiable asthma, it was about
2 35 percent, 34.4 percent.

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

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

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

16 CO-CHAIR CASEY: Yes.

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

19 CO-CHAIR CASEY: Okay.

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

21 CO-CHAIR CASEY: Okay. Thank you.

22 Thank you very much. Okay. So why don't we hear

1 from Ryan, who was the lead on this one?

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

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

6 MEMBER COLLER: Yes.

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

9 MEMBER COLLER: Right. Correct.

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

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

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

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

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

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

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

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

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

1 evidence base.

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

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

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

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

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

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

1 still do have ER visits and hospitalizations for
2 asthma.

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

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

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

22 So we do have an independent count, or

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

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

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

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

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

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

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

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

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

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

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

15 DR. KLEINMAN: Sure.

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

22 DR. KLEINMAN: That's right. And

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

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

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

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

22 We've been sort of scratching our head

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

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

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

18 CO-CHAIR CASEY: And are we really --

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

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

1 right?

2 MEMBER SCHULTZ: Right.

3 CO-CHAIR CASEY: Emma?

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

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

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

1 okay?

2 DR. KLEINMAN: Is it okay --

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

4 DR. KLEINMAN: -- for me to --

5 CO-CHAIR CASEY: Dr. Kleinman, I'm

6 sorry, we're in the Committee right now.

7 DR. KLEINMAN: Okay.

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

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

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

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

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

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

12 MEMBER COLLIER: Yes.

13 CO-CHAIR CASEY: Yes, right. Emma?

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

1 importance.

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

6 MS. OGUNGBEMI: Right.

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

10 MS. OGUNGBEMI: Yes.

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

18 CO-CHAIR CASEY: Thank you, Helen.

19 MEMBER COLLIER: Yes, I -- oh, sorry.

20 CO-CHAIR CASEY: Go ahead.

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

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

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

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

1 that it was Class B evidence for the six months.

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

10 CO-CHAIR CASEY: Thank you.

11 DR. KLEINMAN: -- and --

12 CO-CHAIR CASEY: Thank you.

13 DR. KLEINMAN: Thank you.

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

16 MS. OGUNGBEMI: Yes.

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

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

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

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

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

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

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

13 CO-CHAIR CASEY: Thank you.

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

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

1 passes on evidence.

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

4 MEMBER COLLIER: Performance gap?

5 CO-CHAIR CASEY: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

10 CO-CHAIR CASEY: Emma?

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

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

1 MS. OGUNGBEMI: Yes.

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

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

6 CO-CHAIR CASEY: Sorry, Rich.

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

13 MEMBER COLLIER: I'll defer to Dr.
14 Kleinman. I thought I heard, maybe, there was a
15 corrected number that was somewhere in the 30
16 percent range for the baseline performance of
17 3171, but I defer to him to clarify that.

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

20 MEMBER COLLIER: I think the question
21 was --

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

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

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

19 CO-CHAIR CASEY: You good, Rich?

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

22 MEMBER ANTONELLI: I guess I just

1 wanted to know what we were voting on. So, Dr.
2 Kleinman, are you saying the numbers that we have
3 in our presentation are the correct ones for
4 3170?

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

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

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

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

1 got. Thank you.

2 DR. KLEINMAN: I think that's fine.

3 CO-CHAIR CASEY: Thanks. So Yetunde?

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

8 Results are: 4 votes high, 11 votes
9 moderate, 1 vote low, and 1 vote insufficient.
10 We have 24 percent high, 65 percent moderate, 6
11 percent low, and 6 percent insufficient. Measure
12 3170 passes performance gap.

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

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

19 DR. TERRY: Excuse me. There is the
20 1C, which is a construct, and it is must-pass
21 criterion. So, it's quality construct.

22 CO-CHAIR CASEY: Thank you.

1 DR. TERRY: Thank you.

2 CO-CHAIR CASEY: I'm sorry.

3 DR. TERRY: That's okay.

4 MEMBER SCHULTZ: Okay.

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

7 MEMBER SCHULTZ: Okay. So --

8 CO-CHAIR CASEY: Briefly.

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

13 CO-CHAIR CASEY: Right.

14 MEMBER SCHULTZ: So, I think --

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

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

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

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

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

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

17 CO-CHAIR CASEY: Did you see those
18 comments?

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

21 CO-CHAIR CASEY: Yes.

22 MEMBER KOPLEFF: Could the staff help

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

4 MEMBER ERICKSON: I had help today.

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

7 MEMBER KOPLEFF: Okay.

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

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

20 CO-CHAIR CASEY: Dr. Lamb?

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

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

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

16 CO-CHAIR CASEY: Terry?

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

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

4 CO-CHAIR CASEY: Barbara?

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

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

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

22 CO-CHAIR CASEY: Karen and Brenda, I

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

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

8 CO-CHAIR CASEY: No problem.

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

13 CO-CHAIR CASEY: Thank you. Brenda?

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

22 And there is a role for care

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

5 CO-CHAIR CASEY: Rich?

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

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

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

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

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

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

12 MEMBER ANTONELLI: Yes.

13 CO-CHAIR CASEY: So, I think --

14 MEMBER ANTONELLI: Okay.

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

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

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

4 CO-CHAIR CASEY: Helen, do you --

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

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

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

1 that would be part of this quality construct as
2 well.

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

9 CO-CHAIR CASEY: Thank you, Helen.

10 DR. BURSTIN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 MEMBER COLLER: An opportunity that --

15 CO-CHAIR CASEY: Okay, thank you.

16 MEMBER COLLER: -- would provide
17 support --

18 CO-CHAIR CASEY: Thank you.

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

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

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

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

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

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

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

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

10 I will tell you that, if you look at
11 the population in New York State who have any
12 kind of asthma diagnosis, you'll find about 14
13 percent, 13 to 14 percent have an asthma claim,
14 15 to 16 percent will actually say on a survey
15 that they have asthma, the CAPQuaM measure will
16 identify 8.6 percent with identifiable asthma,
17 and the HEDIS measure will identify between 3 and
18 4 percent as having persistent asthma under those
19 very strict criteria for their hospitalization
20 measure.

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

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

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

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

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

20 CO-CHAIR CASEY: Okay.

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

1 communicating that.

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

9 DR. KLEINMAN: Right. And I would ask
10 --

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

12 DR. KLEINMAN: -- that it be --

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

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

22 CO-CHAIR CASEY: And this is must-pass

1 as well.

2 MS. OGUNGBEMI: Results are: 0 votes
3 high, 2 votes moderate, 1 vote low, and 14 votes
4 insufficient. Percentages are: 0 percent high,
5 12 percent moderate, 6 percent low, and 82
6 percent insufficient. So Measure 3170 does not
7 pass on reliability.

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

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

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

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

4 MS. OGUNGBEMI: Yes, sir.

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

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

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

22 I am not an expert in data on

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

8 CO-CHAIR CASEY: Emma?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 CO-CHAIR CASEY: Great.

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

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

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

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

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

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

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

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

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

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

1 (Laughter.)

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

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

14 The numerator statement is evidence of
15 connection to a primary care medical system
16 following an ED visit, that have a
17 primary/secondary diagnosis of asthma, among
18 children. And the denominator is all the ED
19 visits in which asthma was a primary or secondary
20 diagnosis.

21 Its data source is on claims, level of
22 analysis is at the level of population. The

1 preliminary -- so, in fact, let me pause for a
2 second. So, 3170 looks back, this one kind of
3 looks forward with that ED event being what
4 defines getting into this denominator for this
5 Measure.

6 The -- Ryan did a great job of talking
7 about the linkage to the expert panel, so I won't
8 go into that level of detail, but the evidence
9 basically talks about connecting with that
10 primary care provider within a period of time
11 after an ED visit, with a Composite including the
12 asthma controller and rescue medications going
13 forward.

14 So, the evidence base connects
15 specifically with meds and recommendations to the
16 expert panel recommendations. I -- in fact, let
17 me sort of pause there, because we're going to do
18 this, we're going to chunk this, right? Okay.
19 So, why don't I pause there. Barbara, do you
20 want to weigh in before we open it up for
21 discussion?

22 MEMBER GAGE: I'll just underscore that

1 this is the subsequent, the follow-up care. And
2 I thought that was a real strength, that's a
3 measurable, tieable, event.

4 MEMBER ANTONELLI: Okay. So, any
5 comments or questions from the Committee about
6 the evidence for how this Measure is constructed?
7 In particular, I guess, Ryan and Emma and Ellen,
8 since these are sort of related Measures,
9 anything that you could add, we'd be happy to
10 entertain.

11 MEMBER COLLIER: Just a minor one. I
12 found -- I don't disagree with anything that
13 we've covered already, I'm just -- the question
14 that I had about evidence of filling the
15 controller medicine within two months of an ER
16 visit, what if you don't need it? What if you
17 already have one or something like that?

18 Is the idea just, we're assuming if
19 you've had an ER visit, you are out of meds and
20 need new ones? I guess, I don't know, that was
21 sort of a conceptual challenge I was thinking
22 about.

1 DR. KLEINMAN: Is that an invitation to
2 respond?

3 CO-CHAIR CASEY: We're going to keep
4 going with our --

5 DR. KLEINMAN: Okay.

6 CO-CHAIR CASEY: -- questions and then,
7 we'll -- other questions? And, Rich, you don't
8 have the answer?

9 MEMBER ANTONELLI: For -- so, I --

10 CO-CHAIR CASEY: For Ryan?

11 MEMBER ANTONELLI: -- just wanted to
12 entertain that. So, what I was going to say is,
13 I'm not sure that necessarily I would put the
14 discussion for that question in the Evidence
15 discussion, but I would defer to the Chairs that
16 are much more adept at this.

17 But I do think by the time we start
18 talking about the elements of the Measure, and
19 maybe rolling up to the Composite, I think that's
20 where I'd recommend we have that conversation.
21 But I would defer to the Chairs.

22 CO-CHAIR CASEY: Are you good with

1 that, Ryan? Okay, good.

2 MEMBER COLLIER: Yes, sure.

3 CO-CHAIR CASEY: Good. So, any other
4 questions? We're going to vote on this, right?

5 MS. OGUNGBEMI: Yes.

6 CO-CHAIR CASEY: So, Yetunde's got the
7 clickers on notice to click.

8 MS. OGUNGBEMI: If there's no more
9 discussion, we are now voting on Measure 3171's
10 Evidence. This is the Percentage of Asthma ED
11 Visits followed by Evidence of Care Connection.
12 Your options are: 1, High; 2, Moderate; 3, Low;
13 and 4, Insufficient. Voting is open.

14 CO-CHAIR CASEY: Must-pass. I tried to
15 steal Gerri's clicker so I could vote early and
16 often, but she got it from me.

17 MS. OGUNGBEMI: Results are: two votes
18 High, 14 votes Moderate, one vote Low, and zero
19 votes Insufficient. Twelve percent High, 82
20 percent Moderate, six percent Low, and zero
21 percent Insufficient. Measure 3171 passes
22 Evidence.

1 CO-CHAIR CASEY: Continue, sir.

2 MEMBER ANTONELLI: So, now, we're going
3 to talk about the gap in care and, in particular,
4 the disparities. This is the place where several
5 of us that reviewed these two Measures called out
6 the suspect nature of 16.5 percent.

7 And that was why, Don, I wanted to
8 make sure that I knew what numbers I was voting
9 on for 3170. So, my suggestion is that we give
10 Dr. Kleinman the chance to comment on this and
11 then the Committee can decide if that's
12 sufficient.

13 CO-CHAIR CASEY: The other 16.5
14 percent. And I think he did give us some
15 numbers.

16 MEMBER ANTONELLI: Yes, the numbers
17 that I think he gave us were primarily related to
18 3170. But if he conflated them, then I would
19 like to respectfully request he give us the
20 numbers that are specific for 3171.

21 CO-CHAIR CASEY: And -- why don't we
22 continue through this evaluation, then we can ask

1 him.

2 MEMBER ANTONELLI: Okay. So, we're
3 getting into the gaps and the disparities. There
4 was some performance through, collected through
5 data at New York State Medicaid around race and
6 ethnicity, urbanicity, and poverty. And the --
7 trying to, in my mind, reconcile those numbers is
8 where I'm kind of stuck at this point. Barbara,
9 did you want to add anything to that?

10 MEMBER GAGE: No.

11 MEMBER ANTONELLI: Okay.

12 CO-CHAIR CASEY: So, Rich, let me ask
13 you a question, if it matters. I mean, I might
14 be oversimplifying, but empirically, do you have
15 any reason to believe that these disparities
16 don't exist?

17 MEMBER ANTONELLI: So, empirically and
18 qualitatively, no, I don't question them. It's
19 the very provocative 16.5 percent in two separate
20 Measures that I'm -- on its face, it actually
21 lacks face validity --

22 CO-CHAIR CASEY: Right.

1 MEMBER ANTONELLI: -- to use that term
2 that way.

3 CO-CHAIR CASEY: Very good. Thank you.
4 Okay. You want to keep -- is that it for this
5 section, the gaps?

6 MEMBER ANTONELLI: No. And so, I guess
7 I want to make sure that Larry is in the on-deck
8 circle for him to be able to respond. So I do
9 think that, qualitatively, I think the gaps,
10 specifically in the disparities space, are
11 willing to pass muster until I actually hear the
12 real numbers.

13 I also had the concern, I think I
14 raised this on the prep call a couple weeks ago
15 and I'll bring this back here, is, this is the
16 performance in Medicaid and what would the
17 performance look like in a commercial population
18 as well? And I think that's all I need to bring
19 up right now.

20 CO-CHAIR CASEY: Great. Good. Any
21 comments from the 3170 club?

22 MEMBER GAGE: I wasn't that worried

1 about the data being tied to Medicaid, because I
2 assumed that they would be at higher risk than
3 the commercial population. So, in building the
4 Measure, I thought that was a reasonable
5 approach.

6 CO-CHAIR CASEY: Thank you. Any other
7 questions from the Committee? Dr. Kleinman, do
8 you want to briefly remind us of the data for
9 this one?

10 DR. KLEINMAN: Sure. Happy to do that.
11 So, this is what I have in front of me, we have
12 additional, but I'll just give you this. So, in
13 terms of primary care follow-up visit within 14
14 days after the visit, the number was five percent
15 at the top line, 4.7 percent for blacks, 5.5
16 percent for whites.

17 There's similar -- if you use the 30-
18 day stratification, which is just an attempt to
19 illuminate, but is actually not a Composite,
20 since everybody who has a 14-day fits within the
21 30-day, it would be 7.7 percent, with 7.6 percent
22 for black and 8.3 percent for white children, so

1 about a ten percent difference. And -- I'm
2 hearing beeps, is that -- you guys hear me still?

3 CO-CHAIR CASEY: Yes.

4 DR. KLEINMAN: Okay. So, in terms of
5 controller medications filled within two months,
6 what I have in front of me are the stratified by
7 whether or not there was identifiable asthma.
8 And 34.4 percent of those with identifiable
9 asthma had a controller medication filled within
10 two months and 13.5 percent of those without
11 identifiable asthma.

12 This was an attempt to get at that
13 issue, well, maybe some of them really don't need
14 it, there was some combination of events that got
15 them in the ED, but it really wasn't that they
16 had this intrinsic need for ongoing management.

17 So, we wanted to break it out, so that
18 it could be -- I don't have right in front of me,
19 it should be in the packet somewhere, but I
20 couldn't find it on a quick scan, what the actual
21 composite number was when you pull those all
22 together.

1 CO-CHAIR CASEY: So, let me just --

2 DR. KLEINMAN: But obviously the
3 numbers are small.

4 CO-CHAIR CASEY: Let me just ask a
5 pragmatic question for the Staff. Would it be
6 okay if Dr. Kleinman provided us with these data
7 and could we include them?

8 MS. MUNTHALI: It would be similar to
9 the other Measure. So, you're voting on the
10 Measure -- excuse me, I should be sitting in that
11 corner as well, I have a sore throat. You will
12 be voting on the Measure as it's currently
13 specified. And --

14 DR. KLEINMAN: If I may, this is
15 actually on 2B4.9 Results of Risk Stratification
16 Analysis. So, these numbers actually were
17 submitted.

18 MS. MUNTHALI: So, is it -- we're
19 checking here. Do you see it, Peg?

20 DR. TERRY: I see it.

21 CO-CHAIR CASEY: You see it? Okay.

22 DR. TERRY: Can he say them again?

1 Because I'm not sure they're what I have here.

2 DR. KLEINMAN: Okay. So, 5.0 percent
3 of ED visits for asthma have follow-up visits
4 with primary care within 14 days after the visit,
5 4.7 percent for blacks, 5.5 percent for whites.

6 DR. TERRY: Right. We have those.

7 DR. KLEINMAN: Okay.

8 CO-CHAIR CASEY: And this was just in
9 a different section --

10 DR. TERRY: Yes.

11 CO-CHAIR CASEY: -- of the --

12 DR. KLEINMAN: It was just in a
13 different section.

14 CO-CHAIR CASEY: Yes, okay.

15 MS. MUNTHALI: Okay. So, then, it
16 sounds like the Committee is fine. Okay.

17 CO-CHAIR CASEY: Yes.

18 DR. TERRY: It's 2D.

19 CO-CHAIR CASEY: Ellen?

20 MEMBER SCHULTZ: I think the issue for
21 me is that, so you've given what the breakout is
22 that's stratified, but in the separate location,

1 where you told us what it is when you put the two
2 together, so the number of cases that met both
3 the A and the B criteria, what's stated in this
4 packet is 16.5 percent. And I agree with you --

5 DR. KLEINMAN: Yes, that's an error.

6 MEMBER SCHULTZ: Yes. And that's an
7 error.

8 DR. KLEINMAN: And that's clearly an
9 error.

10 MEMBER SCHULTZ: But we don't know what
11 the real number is.

12 DR. KLEINMAN: You're right. I would
13 --

14 CO-CHAIR CASEY: So, let me just --

15 DR. KLEINMAN: Yes.

16 CO-CHAIR CASEY: -- say, for purposes
17 of our vote, do we feel like we have enough
18 information in spite of the imprecision to vote
19 or do you want to keep trying to clarify the
20 data? What's the feeling, Rich?

21 MEMBER ANTONELLI: I would --

22 CO-CHAIR CASEY: On the gaps.

1 MEMBER ANTONELLI: Yes. It's hard for
2 me to vote without seeing the data, because as a
3 reviewer, that's part of what my obligation is --
4 -

5 CO-CHAIR CASEY: Right.

6 MEMBER ANTONELLI: -- is the due
7 diligence.

8 CO-CHAIR CASEY: And you have the data
9 that's further down now in the --

10 MEMBER ANTONELLI: Yes, but --

11 CO-CHAIR CASEY: -- spec.

12 MEMBER ANTONELLI: I think the -- I
13 don't think that I've heard the composite data.
14 So, we're being asked to review a Composite
15 Measure and that piece is missing.

16 CO-CHAIR CASEY: And the way it's
17 presented in this document is the way we have to
18 vote on it. So, okay. It's not reviewable at
19 this point.

20 MEMBER ANTONELLI: Right. So, it --

21 CO-CHAIR CASEY: And there's some
22 suspicion about that number, right? Okay.

1 MEMBER ANTONELLI: Yes. I'm concerned
2 of --

3 CO-CHAIR CASEY: Right.

4 MEMBER ANTONELLI: -- without --

5 CO-CHAIR CASEY: Right.

6 MEMBER ANTONELLI: -- having that.

7 CO-CHAIR CASEY: Okay.

8 MEMBER GAGE: And the Reliability,
9 like, when we get to that on the next, it's the
10 same issue as --

11 CO-CHAIR CASEY: Right.

12 MEMBER GAGE: -- with the last one.

13 CO-CHAIR CASEY: Right. So, do you
14 feel well enough to vote on this now or do we
15 want to keep going? Is anyone --

16 MS. MUNTHALI: Don, just --

17 CO-CHAIR CASEY: Yes?

18 MS. MUNTHALI: -- one clarification.

19 So, we have Karen Johnson here, some of you know
20 her, she is one of our Senior Directors, but also
21 our Chief Methodologist. And so, she's going to
22 shed some light on the all-or-none Composite.

1 MS. JOHNSON: Just a reminder, I'm sure
2 you guys know this, but since Larry was able to
3 give us, and I couldn't find it in the form, but
4 it was there somewhere, Peg knew where it was,
5 since you know what the two components are, you
6 know that the all-or-none result is going to be
7 less than or equal to the smallest number that
8 was there. So, you don't know what it is, but
9 you know it's going to be something less than or
10 equal to what he's providing. If that helps you
11 any.

12 CO-CHAIR CASEY: And there would be an
13 opportunity in public comment, as well, to
14 clarify this, right? So, can we vote? Please?

15 MS. OGUNGBEMI: We are now voting on
16 Performance Gap for Measure 3171. Your options
17 are: 1, High; 2, Moderate; 3, Low; and 4,
18 Insufficient. Voting is open. Results -- we
19 have 16.

20 Our results are: zero votes High,
21 eight votes Moderate, two votes Low, and six
22 votes Insufficient. Zero percent High, 50

1 percent Moderate, 13 percent Low, and 38 percent
2 Insufficient, so we land in a grey zone. So,
3 consensus is not reached on Measure 3171 for
4 Performance Gap.

5 CO-CHAIR CASEY: Thank you. And,
6 again, there will be an opportunity in public
7 comment to help clarify.

8 MS. MUNTHALI: So, Don, we continue ---

9 CO-CHAIR CASEY: Yes.

10 MS. MUNTHALI: -- with the discussion.

11 CO-CHAIR CASEY: Yes. We won't vote,
12 but we'll continue with the --

13 MS. MUNTHALI: You do vote. Consensus
14 is not reached, you will hopefully resolve this
15 issue, if this Measure goes forward, during the
16 post-comment call. So, you go to the next
17 Criterion and this is a Composite, so we'll go to
18 1C. And if we pass that or consensus is not
19 reached, we'll go to the next Criterion, which is
20 Reliability. So, you will go to the next
21 Criterion, which is 1C --

22 CO-CHAIR CASEY: Okay.

1 MS. MUNTHALI: -- and you will vote on
2 that.

3 CO-CHAIR CASEY: So, we'll keep voting.
4 Rich?

5 MEMBER ANTONELLI: Yes. So, this is
6 the Composite Quality Construct and the
7 rationale. My computer is very slow today, I'm
8 sorry. Okay. The Composite Measures include, we
9 talked about before, the visit to a primary care
10 within 14 days following an ED visit and having
11 at least one fill of a controller med within two
12 months after the ED visit.

13 I think, Ryan, this is probably the
14 place where you could bring up your observation
15 before. I think this also, from my perspective,
16 does call into question, are we measuring the
17 right things, with respect to how this Measure is
18 constructed? Granted, claims in the primary care
19 setting is relatively easy to measure, so I can
20 understand why that would be in, in this Measure
21 at this point.

22 I probably feel similarly to this

1 Measure as I did for 3170 in terms of the rigor,
2 certainly the rigor with which it was put
3 together, but I do think that there are some
4 components that would potentially be missing that
5 I'd like to call out.

6 So, Ryan, I'm not going to steal your
7 thunder, I'll ask you to bring that up again, but
8 I think first I would like to know, is this a
9 child who or a teenager who has an asthma action
10 plan, as something that would be captured with
11 that connection to the primary care provider.
12 So, I'll throw that out there to stimulate some
13 discussion. And, Barbara, I'll hand it to you
14 next, though.

15 MEMBER GAGE: Okay. And, again, not
16 being a clinician, but being a researcher, could
17 you identify that care plan through the claims?
18 And we -- either the Measure is inappropriate,
19 because that information is critical, or the
20 other factors in the Composite are equivalent, in
21 terms of identifying that issue. So, I wouldn't
22 downplay the Measure for not having that, because

1 being able to create it off the claim, I think is
2 valuable.

3 MEMBER ANTONELLI: Yes. So, I actually
4 agree with that statement as well. That said,
5 and I do want to bring us back, this is a Care
6 Coordination Measure, or at least we're being
7 asked to think about the Care Coordination
8 Measure, and there are codes around care plan
9 development that can be tracked that would not
10 just be the visit code.

11 CO-CHAIR CASEY: Specifically for
12 asthma?

13 MEMBER ANTONELLI: I don't think it's
14 specifically for asthma, but there are care
15 coordination codes.

16 CO-CHAIR CASEY: Right.

17 MEMBER ANTONELLI: I helped write the
18 language that went to the RUC on that one and we
19 purposefully kept it broad.

20 CO-CHAIR CASEY: Good. Okay. I think
21 we've got Karen with her card up there.

22 MEMBER MICHAEL: In my mind, the

1 issue's not the inclusion of the asthma action
2 plan, because I think administratively that would
3 be hard to gather, even with care coordination
4 codes.

5 In my mind, the question on the
6 Composite relates to the medication, the need for
7 the medication within the time period after the
8 ER visit. I think that's where this Measure is
9 going to fall out, because you're going to have
10 some members who either the medication really
11 isn't appropriate for or they've got the supply,
12 because they had a three-month fill before.

13 MEMBER ANTONELLI: Did you want to
14 weigh in, Ryan?

15 MEMBER COLLIER: No, I think you guys
16 both covered --

17 CO-CHAIR CASEY: Yes, okay.

18 MEMBER COLLIER: -- the same point I
19 had.

20 CO-CHAIR CASEY: Any other Committee
21 Members? I do think the NHLBI specifies very
22 specific evidence-based elements of a care plan

1 for childhood asthma pretty clearly. Yes,
2 Barbara?

3 MEMBER GAGE: While the codes may
4 exist, oftentimes the way codes are reported in
5 the claims are, if they're not important for
6 payment or regulatory purposes, that they may not
7 be present, so you might be undercounting.

8 CO-CHAIR CASEY: Well, these are now
9 part of payment policy. It's just that they're
10 not specific to asthma, I'm pretty sure of that.
11 So, we won't get into it. Yes, Charissa?

12 MEMBER PACELLA: So, mine is an ED
13 related comment that I was going to hold for
14 Validity, but since it relates to the other two,
15 what I'm going to say is, there are also, in
16 addition to the presumption that the patient
17 needs medication within those two months, there's
18 also a presumption that if there wasn't a claim
19 for a prescription being filled, that you didn't
20 get it or don't have it.

21 And many EDs and other places actually
22 have funded programs that are dispensing, have

1 providers dispensing these medications. We don't
2 let an asthmatic leave our ED without an inhaler
3 in hand and yet, there would be no separate claim
4 for that, necessarily, in a prescription. So,
5 I'm not sure how you would track or even know
6 that.

7 CO-CHAIR CASEY: Yes. And just let me
8 put in here that, we know that the public comment
9 is on the schedule for 12:30 and we're going to
10 allow that as soon as we finish up here. So,
11 hang in there, we haven't forgotten about you.
12 So, any other questions? Yes, Ellen?

13 MEMBER SCHULTZ: I would just say that,
14 this discussion around the medication and some of
15 the discussion around what happens at the primary
16 care visit and an asthma action plan makes me
17 wonder that this shouldn't be an either/or
18 Measure.

19 Looking at the stratification that was
20 provided, at best, the performance would be
21 around 35 percent, I think, if I'm looking at
22 that correctly, which still leaves plenty of room

1 for improvement.

2 And so, meeting the numerator by
3 either having a follow-up primary care visit or
4 having a fill for medication, to me, seems like
5 it could balance some of these concerns around
6 cases where good care may have been provided, but
7 it wouldn't be captured by the Measure.

8 CO-CHAIR CASEY: Thank you. All right.
9 Seeing no upright cards, Yetunde?

10 MS. OGUNGBEMI: We are now voting on
11 the Composite for Measure 3171. Your options --

12 DR. KLEINMAN: Is it possible that I
13 could respond to some of those comments? Because
14 I think there's some --

15 CO-CHAIR CASEY: I think, with all
16 positivity here, we're going to move on, because
17 I think the group has enough information here.
18 We appreciate your presence, but I think, at this
19 point, we want to get through the vote.

20 DR. KLEINMAN: I appreciate it.
21 There's specific reasons for the 60-day fill that
22 I thought might be helpful.

1 CO-CHAIR CASEY: That's -- I think
2 we'll postpone that.

3 MS. OGUNGBEMI: Your options are: 1,
4 High; 2, Moderate; 3, Low; and 4, Insufficient.
5 Voting is open. Results are: zero votes High,
6 six votes Moderate, nine votes Low, and two votes
7 Insufficient. Zero percent High, 35 percent
8 Moderate, 53 percent Low, and 12 percent
9 Insufficient. Measure 3171 does not pass the
10 Composite.

11 CO-CHAIR CASEY: So, we -- would it be
12 fair, Rich, to expect that, since we're not going
13 to vote further, if we were to get to
14 Reliability, we would have the same sort of type
15 of results as we did, in your estimation?

16 MEMBER ANTONELLI: Yes.

17 CO-CHAIR CASEY: So, I think that --
18 let's just go through the rest of the information
19 that you worked hard on and provide that and have
20 public comment. And then, I think we'll be done.
21 And I think, for the Measure Developer,
22 certainly, any of the things that you want to

1 highlight will be well served by the public
2 comment period. So, take that as your
3 opportunity.

4 DR. KLEINMAN: Okay.

5 MEMBER ANTONELLI: So, the Reliability
6 for 3171, analogous to the conversation we had
7 with 3170, is limited by the lack of data. I
8 appreciate Dr. Kleinman's description and
9 actually, in my view, a rational justification
10 for why there is a gap there.

11 As the lead discussant, though, I
12 would want to make sure that we can transmit to
13 the Measure Developer and his team that -- bring
14 on the data, because there are elements of this
15 Measure that are attractive. So, I think I'm a
16 bit at a loss to give much more information about
17 the reliability testing, absent the data.

18 With respect to Validity and validity
19 testing, the -- pulling up my notes here. I
20 think that the discussion that Dr. Kleinman had
21 provided to us was helpful in terms of defining
22 the population.

1 I think that the discussion about who
2 would fall out of the Measure, that don't have
3 asthma, but may actually present with asthma, is,
4 in my opinion, is spot-on. The -- with respect
5 to exclusions, cystic fibrosis, for example, the
6 ability or the need to risk-adjust was limited
7 and so, therefore, that was fine, in my view.

8 The -- so, I think, basically, it is
9 -- accepting it as a Composite Measure, with the
10 appropriate data to consider, it is something
11 that we're willing to consider. But I think I
12 basically will end my assessment by saying, let's
13 see more data, with the public comment period
14 coming forward. Barbara, do you want to add
15 anything to this?

16 MEMBER GAGE: I echo all that and
17 further support the lack of a need for a risk
18 adjustor, because this is kind of -- you would
19 expect, regardless of race, age, sex, et cetera -
20 -

21 MEMBER ANTONELLI: Right.

22 MEMBER GAGE: -- that this would be

1 carried out.

2 MEMBER ANTONELLI: Yes. And then, in
3 terms of the Feasibility, I don't have any
4 concerns about how the Feasibility was discussed
5 in the analysis. The Usability and Use, the -- I
6 can't imagine Measures that identify at-risk sub-
7 populations in pediatrics not looking for a
8 Measure like this to move forward into
9 accountable care.

10 Being close enough to multiple ACOs
11 around the country formulation, I can -- asthma,
12 asthma, and asthma are probably the three top
13 vote-getters. And so, I think, with the
14 Usability, I think that there is potential with
15 this going forward, once some of our concerns
16 have been addressed.

17 And then, I think, Don, you had said,
18 talking about harmonization, would be a
19 conversation for later, right? So, we can --
20 I'll close my comments with that and, Barbara,
21 give you a chance.

22 MEMBER GAGE: Again, just in terms of

1 the Usability, even though it's not in use, it
2 seems directly related to preventing adverse
3 events. And so, pretty important.

4 CO-CHAIR CASEY: So, we have one last
5 task. Elisa wants to get some feedback from the
6 Committee about the vote that did not pass, 1C.

7 MS. MUNTHALI: Hi. Yes. So, we rarely
8 see votes, Measures go down on 1C, on the
9 Composite Construct. So, we do, for the purpose
10 of our report, want to get a little more
11 understanding from the Committee, a rationale
12 behind your vote. And it sounds like it may be
13 because of the exclusion of that third component,
14 but we just want to make sure.

15 CO-CHAIR CASEY: Any comments or
16 questions? Do you understand what she's asking
17 for?

18 MS. MUNTHALI: And --

19 MEMBER ANTONELLI: Could we put the
20 relevant language here --

21 MS. MUNTHALI: Yes.

22 MEMBER ANTONELLI: -- so everybody can

1 be looking at it, please?

2 CO-CHAIR CASEY: I'm getting dizzy.

3 Down, 1C.

4 MEMBER ANTONELLI: And these are the
5 comments. I think it should be a little bit
6 north of that, right?

7 CO-CHAIR CASEY: North? Okay, you're
8 right. Sorry. There we go.

9 MEMBER ANTONELLI: There we go.

10 CO-CHAIR CASEY: Yes.

11 MEMBER ANTONELLI: Right there. Okay.
12 So, I will start. This is around the Construct
13 of this as a Composite Measure. I think we had -
14 - we received some comments related to the fact
15 of a medication within that window of time.

16 I think our emergency department
17 colleague from Pittsburgh also called out that
18 medications might have been provided that
19 wouldn't necessarily track into a claims data
20 flow. And then, the Construct itself, about
21 following up with a so-called primary care
22 connection.

1 That is a claims visit, but I would
2 argue that many medical homes get a list on a
3 daily basis of patients that went to the ED and
4 so, there could be a lot of care coordination
5 that's done telephonically, for example.

6 Oh, Sally ran out of her inhaler.
7 Well, let me renew that. You don't have to come
8 in and see Dr. Collier today, because she has an
9 asthma action plan and you should have called us,
10 Mrs. Jones, that she needed a refill, but we'll
11 go ahead and make that happen.

12 So, there are aspects of -- and I
13 think this is why I actually think 3171 is a more
14 reflective measure of care coordination and I
15 think of 3170 as being more a care management.
16 Yes, there's some overlap between the two, I feel
17 that that's absolutely arguable.

18 But in my view, I think that this
19 really gets at the heart of what good care
20 coordination could do. So, those are my
21 comments, but let's make sure to open up, I want
22 to make sure that I quoted Karen and Ryan and

1 others correctly.

2 CO-CHAIR CASEY: Ellen, do you want to?

3 MEMBER SCHULTZ: I would just say, so,
4 I voted Low on this Criterion, because, to my
5 mind, after the discussion, I feel like it might
6 be better as an either/or.

7 CO-CHAIR CASEY: Hence, the composite
8 nature of it maybe not being as nice as -- good
9 as you'd like it.

10 MEMBER SCHULTZ: Well, just, so, in
11 terms of, like, how are the components weighted?

12 CO-CHAIR CASEY: Right.

13 MEMBER SCHULTZ: That's what that comes
14 down to.

15 CO-CHAIR CASEY: Always a problem.
16 Yes. Terry?

17 MEMBER O'MALLEY: Ditto to that. And
18 I think the components themselves are good, just
19 as a composite, they're too exclusive, hard to
20 meet.

21 CO-CHAIR CASEY: Very good. Well,
22 you've certainly earned your lunch. Let me just

1 ask, I don't think we got, Katie, evidence of
2 anyone who wanted to submit public comment. We
3 do have -- do we have anyone in the audience? Is
4 there anyone on the phone that wishes to submit,
5 to give us oral public comment?

6 OPERATOR: At this time, if you would
7 like to make a comment, please press Star 1.

8 CO-CHAIR CASEY: So, please press Star
9 1 on your phone.

10 OPERATOR: There are no public comments
11 from the phone line.

12 CO-CHAIR CASEY: Thank you, Operator.

13 CO-CHAIR LAMB: One of the things we
14 were wondering is, we need to get through the
15 other four Measures, but we also wanted a chance
16 to have everybody weigh in on Gaps and what we're
17 thinking about on a go-forward.

18 How would you feel about taking about
19 ten minutes or so to get lunch and then, start
20 the Gaps discussion, move into the rest of the
21 Measures, and then, assuming we'll have time at
22 the end, we'll go back to Gaps, but otherwise, we

1 may not get to Gaps? How would you feel about
2 that? Is that all right with everybody?

3 CO-CHAIR CASEY: Let me ask a related
4 question. How many of you cannot stay until the
5 4:00 end time? 5:00, excuse me, I'm on Central
6 Time. Two and a half people? Is that --

7 CO-CHAIR LAMB: Three, I think there's
8 three.

9 CO-CHAIR CASEY: Three? So, we still
10 will have a quorum, will we not? And we would
11 hope, if you're on the phone, you could patch in
12 on your way to the airport or something. So,
13 let's break for lunch and then, Gerri, we're
14 going to --

15 CO-CHAIR LAMB: We're going to move
16 into --

17 CO-CHAIR CASEY: We're going to move
18 into that and sort of have our lunch and --

19 CO-CHAIR LAMB: So, come back at about
20 five after and we'll just kind of start the
21 discussion and then move into CDP.

22 (Whereupon, the above-entitled matter

1 went off the record at 12:53 p.m. and resumed at
2 1:08 p.m.)

3 CO-CHAIR LAMB: So this is kind of a
4 -- it's a beginning salvo into Gaps, and what Don
5 was referring as aspirational, Chris was talking
6 about bridge measures, okay. I think we really
7 got our feet wet into that with the last two
8 measures in terms of where do we want to go from
9 here.

10 So just a couple of things to get us
11 started, and then we're just going to open it up,
12 because as we shared in the beginning, this
13 standing committee's responsibility is ongoing.
14 We're looking at the portfolio of care
15 coordination in addition to CDP.

16 So just, you know, in terms of what
17 has been mentioned so far, just to -- and I'm
18 sure the NQF staff have been tracking this, in
19 terms of each of the measures that we have looked
20 at so far in terms of aspiration of the alignment
21 with payment codes, I think the overall theme of
22 these are important measures. We want to kind of

1 keep up to date with where things are going.

2 So aligning the measurement codes, the
3 measures with the CPT codes, the whole issue that
4 we just got into with 3170 and 3171 was the
5 composites and what is meaningful in those
6 composites, and we had that whole dialogue of how
7 do we really capture care coordination, and how
8 do we do it in a feasible way when some of the
9 data is available on the EMR and some of it
10 isn't. So all of that is aspirational.

11 One of the things I've wanted to call
12 out is in our off cycle work, and again these
13 summaries are available for you in the
14 Sharepoint, some of the things that the folks who
15 participated in off cycle recommended as steps
16 for this Committee.

17 I wanted to throw these you so if you
18 want to reflect on them, you have the chance to
19 do that, was one was that we could keep our eye
20 on the whole portfolio, because one of the issues
21 that we're dealing with is not all the care
22 coordination measures come to us.

1 They may go to other committees and
2 sometimes we'll be aware of that, sometimes we
3 may not. But one of the things that we proposed
4 during off cycle is that we really keep our arms
5 around the whole portfolio and look at the
6 aspiration. So one thing that Don and I were
7 bouncing around was is this a good year to do an
8 analysis of the whole care coordination
9 portfolio, and you know, what are the strengths,
10 what are we missing and so forth. So we'd be
11 really interested in your thoughts on that, okay.

12 Another one is to anticipate the needs
13 for the field, and I think we've had a lot of
14 that discussion. So we really are looking at
15 where's the portfolio, what new measures do we
16 need, and how do we really address the evolution
17 of the field, to get back to what Chris is
18 talking about is bridging measures and
19 aspirational measures.

20 So with that, you know, for the next
21 ten minutes or so let's just kind of have an
22 open-ended discussion of your thoughts on wither

1 the field, what's missing from what we've seen,
2 and also if you want to comment on the idea of
3 really taking a look at the whole portfolio as a
4 group.

5 CO-CHAIR CASEY: Let me start by
6 saying thanks to Gerri, and I would also ask that
7 the new members, if you haven't and I don't know
8 if staff is able to locate these, but if you
9 would promise us that you would go to the most
10 recent version of the preferred practices and
11 really look hard at those as a list of ideas,
12 because I think it will help frame set.

13 You know, I think that if we're just
14 speaking amongst friends here, a lot of what
15 we've seen throughout the course of this standing
16 committee is really provider-centric type
17 measures, many of which are focused on hospitals
18 and EDs. When I think of care coordination, I
19 think of life without those two, right, not that
20 providers aren't important.

21 I think we tried to make this clear in
22 the preferred practices, but you know, we'd

1 certainly like to get your perspective, you know.
2 Up here is good, but in the middle of, you know,
3 translating a good idea into something that's
4 tangibly beneficial that we can feed back to
5 measure developers would be useful because, you
6 know, most care coordination takes place outside
7 of those realms, right.

8 So while I know that that's been our
9 discussion, I think that's been where we've tried
10 to take the world and, you know, as we can see
11 we're still stuck in this traditional environment
12 with measure developers. So that's my two cents.

13 MEMBER PACELLA: So I was a little
14 disappointed, you know, in looking through the
15 list of measures in terms of care coordination.
16 I see some of the biggest gaps as occurring
17 between very -- in very actionable settings,
18 which would be sort of between emergency
19 departments and chronic care facilities, and
20 emergency departments and people who are already
21 in home care.

22 So I was really disappointed that the

1 only ED-based measure, you know, on the list is
2 one focused on discharges. My impression is that
3 the performance gaps and the impact of closing
4 those gaps would be far, far less than the bang
5 for your buck that you would get if you could
6 actually demand, you know, two-way communication
7 in a closed loop around why a patient comes from
8 a care setting to an emergency department, and
9 then on the back end why a patient goes from an
10 emergency department back to their setting and
11 what their additional needs might or might not
12 be.

13 CO-CHAIR CASEY: Charissa, could I --
14 can I modify your idea by suggesting it be three-
15 way, potentially with patients and caregivers as
16 the third leg?

17 MEMBER PACELLA: Absolutely.

18 MEMBER O'MALLEY: Yeah. I'm glad that
19 was brought up Don, thanks, because I think we
20 need some patient-centered outcomes, and I will
21 introduce my compatriot next door who has
22 actually developed a measure published on it, and

1 it's called Care Integration. It's just a
2 different slice through care coordination from
3 the perception of in this case the family and the
4 child.

5 So (a), I would put that forward as
6 one and we're just going to keep going as well,
7 to two other things. The extension of care
8 coordination has to go across the entire
9 continuum of care, as we alluded. It's got to
10 include both acute care sites and even, and more
11 importantly, into the home-based care models, the
12 community-based service providers.

13 One of the difficulties in that, one
14 of the many difficulties in building measures
15 that can extend across the continuum is that
16 there's no shared information platform across the
17 continuum. So we're going to be going back to
18 the facts found in paper. It's not going to be
19 electronic, at least not for many years, for a
20 variety of reasons. So just to make sure that
21 that's in place.

22 But perhaps the only unifying piece

1 across the continuum is the individual themselves
2 and their experience of coordinating care. So I
3 think if we don't lose sight of that, we'll be in
4 good stead. So --

5 CO-CHAIR LAMB: Brenda.

6 MEMBER LEATH: Thank you, and what I
7 would like to suggest is that we consider
8 community-based care coordination, which
9 incorporates not only the movement between health
10 care organizations but Health and Human Service
11 organizations, and on top of that I'd like to
12 add, just based on the work that I'm involved in,
13 taking a look at coordination among organizations
14 that perform care coordination services. So
15 that's what I would like to contribute.

16 CO-CHAIR LAMB: Ellen.

17 MEMBER SCHULTZ: Yeah. I want to
18 really echo what both Terry and Brenda said. On
19 the one hand I think there's going to be a
20 recognition that we need to make the tent bigger.
21 It's not just about connecting the dots of what's
22 traditionally been sort of the medical care

1 system, but we need to connect up with community
2 services and, you know, things like dental,
3 things like behavioral health.

4 I mean there's a huge division there
5 that needs to be bridged, where there's a lot of
6 demand for care coordination. To Terry's point,
7 you know, right now with all the fragmentation in
8 our system and the way that we document care
9 coordination, it's the patient or their immediate
10 caregivers who help coordinate their care.
11 They're the one thing that connects all those
12 dots.

13 I've spent the last 15 months on a
14 separate project trying to reimagine what does
15 health care measurement look like if we see it
16 through a patient-centered lens? This goes way
17 beyond just care coordination, but you know, that
18 to me is a really big missing piece. Like we're
19 not hearing enough from patients and caregivers
20 directly, and I think that's a voice that we
21 would do well to bring into the conversation.

22 That might really change how we see

1 things, and particularly anything that this
2 Committee does or the NQF does to think about,
3 you know, calling out gaps and pushing the
4 envelope, trying to be really aspirational. If
5 we don't include that patient and family-centered
6 perspective, like why are we bothering?

7 MEMBER HOHL: This is Dawn. I would
8 100 percent echo what you said, because I was
9 thinking when someone else had made a mention. I
10 know we've started like a patient family advisory
11 group a couple of years, and I'll tell you it has
12 really revolutionized our thinking on many things
13 we're doing. I think that was a great idea. I
14 think we get insights.

15 CO-CHAIR LAMB: Thanks.

16 MEMBER DEZII: Yeah, I've been working
17 with the National Health Council trying to
18 develop initiatives and support the activation
19 and engagement of patients. You know, you hear
20 the patient voice, the patient voice and you know
21 why they say stuff and nothing sticks. Also,
22 also you know, involving patients in decisions

1 and shared decisions is not passing all of the
2 decision to them, because patients are ill
3 equipped.

4 There's a long way to go in energizing
5 them and they need to be part of the -- they need
6 to be here in a way. There's a lot of the
7 things they can't comment on. But you know, that
8 has to be in mind. Terry just made me go back 30
9 years to paper and faxes and what's going on with
10 this machine. It's been out of paper for like a
11 week.

12 I wonder if a step up, a step up is
13 email and PDFs, you know. I know that carries
14 its own kind of thing. And also I'm thinking,
15 you know it's -- we get the measures that the
16 measures developers present to us. So there has
17 to be a way or there should be a way to get them
18 to focus. Further downstream, like Charissa
19 mentioned, you know, the linkages with the
20 external community, you know.

21 Maybe the measures should be rather
22 than her do something and ship somebody out is

1 wherever somebody is to be able to get shipped to
2 won't accept what they get until they get what
3 they need. It's just a different, it's just a
4 different perspective. You know, for example all
5 hospitals value an ER person.

6 I mean, you know, you'll get some
7 action at some facilities. We will not accept
8 this patient until, you know, we have what we
9 need. I mean that will happen once right, and
10 then it won't happen again. I'm sorry. It was a
11 little long-winded and but that's --

12 CO-CHAIR LAMB: That's okay. Samira?

13 MEMBER BECKWITH: I think is a very
14 appropriate conversation to have, and I guess I
15 would just say from myself very heartwarming,
16 because I started in the 70's with hospice care
17 and wanting care to be different for people than
18 it was in the traditional health care system. So
19 I feel like I've waited 35-40 years for this
20 conversation, and to be a part of it is really
21 very heartwarming for me.

22 I would just agree with what everybody

1 has said. It's not just one component of care
2 that's going to make it possible. We have to
3 think about the future of our country and the
4 entire health care system, and you know, having
5 my roots in hospice care now branching out and
6 providing PACE and all these additional programs,
7 trying to cobble it together in a way to provide
8 the care that people need in the system that
9 doesn't pay the way that really pays for
10 coordinated care.

11 I think this is the beginning of
12 moving the system forward, so I find this all
13 very exciting.

14 CO-CHAIR LAMB: Shari.

15 MEMBER ERICKSON: So I just want to
16 echo again I think what Ellen said down there. I
17 mean that has -- the patient really, looking at
18 it from that perspective, has to be the guiding
19 light so to speak for moving performance
20 measurement forward.

21 I think there's absolutely no question
22 of that, and we're not -- it's just if we don't

1 start to do that and think about how to do that,
2 and I think NQF can have a role in trying to help
3 all the different stakeholders around the table
4 figure out how to do that.

5 I think that would be absolutely, you
6 know, getting outside of, you know, and the CDP
7 is critically important. It needs to continue,
8 but getting outside of that box and thinking out
9 of that box to help the movement move forward.

10 The other thing I would say, you know, is what I
11 hear a lot from those that are -- and members of
12 ACP that are really actively engaged in
13 implementing measures in their systems, who care
14 a lot about them, who understand the importance
15 of measurement, that even measures that they find
16 that NQF has endorsed that the MAP has
17 recommended, that you know are being used, that
18 are clinically relevant, valid, all of these
19 things, when you implement them there are things
20 that happen in a system that are unexpected in
21 terms of how the data are collected, in terms of
22 how the, you know, the way --

1 And it can be variable across systems,
2 but and that can vary and unexpected burdens on
3 those that are trying to do the right thing. To
4 the extent that NQF could help, you know, look at
5 that and really this fits in use and usability,
6 you know. How can we better understand, I guess
7 it's post-market surveillance? How can we
8 understand what those issues are, and you can get
9 -- I can get tons of use pieces. I can collect
10 them all day long from members saying this is the
11 problem with this and maybe they're just doing it
12 wrong? It may be.

13 But you know, when it's in a large
14 system or something like that, you know, it gets
15 integrated. And so, you know, to the extent that
16 that feedback can come in and help influence the
17 process, I think that would be -- that would be
18 so meaningful to those on the ground who really
19 want to do the right thing at the right time for
20 the right patients, but just -- it just gets in
21 the way.

22 CO-CHAIR LAMB: And I would just add

1 to Shari that we're also a voice for that. We
2 only have about five minutes more before we move
3 into CDP. Let me just turn to the phone. Lorna
4 or Marcia, do you have anything that you would
5 like to share related to Gaps. Hopefully we'll
6 have time at the end. If we don't, this
7 discussion will continue. But it's just good to
8 have it face to face. Lorna, any comments you
9 want to make or talk to us?

10 (No response.)

11 CO-CHAIR LAMB: Okay, Marcia?

12 MEMBER JAMES: Hi. No, I'm just
13 listening and I wish I could be there. But I'm
14 in an airport getting ready to get on a flight,
15 so I'm listening in on the conversation, though.
16 I don't have anything else to add, thanks.

17 CO-CHAIR CASEY: Gerri, I just wanted
18 to dovetail with what Shari said, by reminding
19 you that you might have seen a piece in the New
20 York Times probably a couple of years ago, which
21 was loosely writ. The challenges of coordinating
22 the care coordinators, you know, which is also a

1 problem.

2 There's a metal level where you've got
3 so many people coming at you trying to be
4 helpful. But it really is a big challenge, I
5 think.

6 CO-CHAIR LAMB: I'm going to ask those
7 of you who have your names up, if you could
8 limit, just so we get the ideas out and hopefully
9 we'll get back to it. But limit your comment to
10 what's most important and you've got a minute.
11 I'm going to do Don here again. So Chris, you've
12 got a minute. Okay, you're going to turn it
13 over. Who are you giving it over to, Rich?

14 MEMBER ANTONELLI: And I can do this
15 in 60 seconds. So first of all I want to voice
16 my enthusiastic support for the suggestion that
17 you made about doing a measure review, and Don, I
18 think the ability to cross-walk on an
19 hierarchical basis to the preferred practices,
20 it's elegant. We need it like yesterday.

21 In '09, the Commonwealth Fund asked us
22 to do a policy brief, and we actually said care

1 coordination is a set of activities and
2 processes. I think one of the things that I
3 struggle with inside this Committee is that's why
4 we see some of these measures of, you know, did a
5 fax a piece of paper, etcetera.

6 So we, in our work in Boston and some
7 of the places that we're consulting with actually
8 globally now is looking at person-centered care.
9 So to the degree that the NQF or those of us that
10 are key stakeholders would want to use language
11 that seems like it's going to be getting
12 increasingly universally accepted, to be focusing
13 on the outcome of integration.

14 And then what happens in the realm of
15 activities, tools and processes of care
16 coordination, those become intermediary measures.
17 And so I wish that I could control the name of
18 this Committee, because to the degree that we're
19 thinking about outcomes, this should be the
20 standing committee on care integration, and that
21 we would then look at does this map to
22 activities, small M map, does this map to

1 activities that we could measure in an EMR, in an
2 EHR.

3 But the outcome is actually the
4 person, family caregiver unit. So I struggle
5 with this concept. I think the field has moved
6 actually thinking about care coordination as
7 tactics, and the strategy is integration. That,
8 Brenda, is how we bring in those community-based
9 organizations. That's the only line of sight I
10 have strategically in building a Medicaid ACO for
11 children, for mitigating social determinants of
12 health.

13 For some reason I can't talk my
14 neurosurgeons into ameliorating poverty. Imagine
15 that. But this is how you build community
16 linkages. Thank you.

17 CO-CHAIR LAMB: Thanks. Okay Emma,
18 one minute.

19 MEMBER KOPLEFF: Okay, a tough act to
20 follow. No, thank you, Rich. I just wanted to
21 ask that our report for this Committee reflect
22 two different kinds of gaps, which I think have

1 been addressed. But one is a lot of this
2 discussion right now has been about the big
3 picture concepts, and I'm not going to repeat
4 what Rich said, but he so eloquently put together
5 this framework for how potentially this group
6 could move forward the field of concepts like
7 patient-centeredness.

8 But I think there's a lot of detailed
9 work and detailed discussion to be had that we're
10 not going to have the chance to have in one
11 meeting. So A, the recommendation should do more
12 of that in off cycle or whenever that may be.

13 Two, I just want to make sure that
14 some of the gaps identified as they relate to our
15 bridge-building measures as we've called them
16 today, so the measures we've already reviewed or
17 perhaps that we're about to review, where we
18 recognize this measure is getting us here, but
19 where we really want to go is here.

20 There's some specifics there that
21 we've hopefully had our developers here, but not
22 all of them were mentioned. For example, with

1 advance care plans, we talked about the concept
2 of one care plan. I don't think we've mentioned
3 the concept of extending the denominator to a
4 population beyond just those 65 and older.

5 Some of those sort of specific nuggets
6 that take the measures as they exist now and
7 perhaps all that we can achieve now, and
8 gradually sort of see them on a path forward, to
9 get us to some of these -- to where we want to
10 go. So thanks.

11 CO-CHAIR LAMB: Thanks Emma. Jeff.

12 MEMBER WIEFERICH: I can't be quiet
13 without putting a plug in for behavioral health.
14 I want to thank Ellen for being the first to
15 bring it up, having the connection with
16 behavioral health and also Brenda talked about
17 the community workers. Those are two critical
18 areas in specialty in terms of what I've seen in
19 terms of the care people need.

20 So we need to be sure we include those
21 components if we're going to be looking at the
22 entire picture and the entire individual.

1 DR. WILSON: Sure. Hi, my name is
2 Marcia Wilson. I'm senior vice president here at
3 National Quality Forum. This has been a great
4 discussion. I know it will continue later on
5 today. But I wanted to let you know about three
6 projects here at NQF that are very much related
7 to your work, and it's one of the reasons that
8 I'm in the room and several of my colleagues are
9 in the room.

10 First of all, National Health Council
11 has a grant from PCORI to develop a quality
12 curriculum, a curriculum about what is quality,
13 why do we care about performance measures that
14 their associations can use. And you know their
15 associations are patients and caregivers.

16 We are part of that grant, so we sit
17 in with them. We share resources with them. So
18 that's a first thing. The second thing is I only
19 have a minute, so I should talk very fast. We
20 have a project funded by the Centers for Medicare
21 and Medicaid Services on emergency department
22 transitions of care.

1 So we are specifically looking at that
2 patient that comes into the emergency room and
3 goes back out to the emergency room. They could
4 come from anywhere, they could go anywhere. What
5 makes for a quality transition of care? How are
6 we measuring that? And actually Terry O'Malley
7 was gracious enough to be a key informant along
8 with our expert panel to give us more
9 information, so we really appreciate his work.

10 And then the third thing I would say
11 is one of our strategic initiatives here at
12 National Quality Forum is feedback on measures,
13 and I think I've just heard that comment, which
14 is we're going to be working with some of our
15 member organizations, and we would work with
16 organizations who are not members to get enhanced
17 expanded feedback on measures.

18 When measures come back for
19 maintenance and review, you want to know what
20 happened to the measures when they went out in
21 the field? What were the implementation issues?
22 Did behavior change? Did processes change? What

1 was the good, the bad and the ugly about those
2 measures?

3 So we are actually having a group
4 tomorrow that's going to be chatting with us
5 about how this initiative will roll out. We have
6 a couple of member organizations who said we
7 would like to work with you and reach out to our
8 members that give you feedback on measures.

9 So more to come on that, stay tuned.
10 But thank you all very much for your discussion.
11 I just wanted to try and connect the dots with
12 some of the other NQF work. I think that was a
13 minute and a half.

14 CO-CHAIR LAMB: That's great, Marcia.
15 We're going to move back into CDP. Hopefully, we
16 will have a chance, one minute. Oh you're done?

17 (Off mic comment.)

18 CO-CHAIR LAMB: Okay.

19 MEMBER DEZII: It's related to what
20 Richard said, so I remembered what I wanted to
21 say. Perhaps another domain, and it would be
22 even beyond this but frankly linkage to the

1 continuum, linkage to the continuum. How the
2 measure is linked to the continuum to have folks
3 think about where, you know, that stuff.

4 It would be nice to be able to read
5 stuff from these measures that speaks to that.
6 That's it.

7 CO-CHAIR LAMB: Thank you, Chris.
8 Just a couple of things. We will come back to
9 this hopefully. This will be a continuing
10 dialogue in addition to our CDP work. I would
11 just also, as Don has already encouraged you,
12 take a look at the preferred practices, because I
13 think it speaks to several of the gap areas that
14 we've just mentioned.

15 The other is to take a look at the
16 measure domains from 2014, because it may be a
17 place that we want to go back to in terms of some
18 of the core constructs that you've just
19 mentioned. If you look at the core domains,
20 okay, person-centered, plan of care, health care
21 neighborhood, which is a much broader continuum
22 construct, and then the outcomes from the person

1 -- person's point of view.

2 Those are already in the framework.
3 What we're talking about here is how do we get,
4 as several of you have said, from here to the
5 aspirational framework. So please keep those in
6 mind when we come back to it. This is a very
7 rich and as Samira is saying very important
8 discussion.

9 CO-CHAIR CASEY: Gerri, let me just
10 say that the other thing here is care
11 coordination happens and so what, right? What's
12 the impact, right? We've got to finish that
13 sentence.

14 CO-CHAIR LAMB: That's great. It took
15 ten seconds. It's very true. We're doing
16 outcomes, and that's going to be an absolute
17 critical piece. Okay. So I think you've all
18 said it is taking our CDP in context of where are
19 we now, evaluating them where we are now, okay,
20 and then aspirationally becomes our gap
21 discussion.

22 Okay. We're now on to 646, and our

1 measure developers are with us, and so 646,
2 Reconciled Med List Received by Discharged
3 Patients. Chris, are you up first? Okay. Oh,
4 excuse me. I'm sorry. The measure developers
5 get their five minutes of fame here. Sorry.

6 MS. CHAVARRIA: Thank you so much. I
7 work from the PCPI and my colleagues and I are
8 happy to be here and to present our measures, and
9 thank you for your time in reviewing them. So
10 the PCPI measures are developed by multi-
11 disciplinary and multi-specialty expert work
12 groups. The PCPI expert work groups do develop
13 these measures based on clinical guideline
14 recommendations, supporting by high level
15 evidence.

16 However, in some instances,
17 performance measures do not lend themselves to
18 rigorous studies including randomized control
19 trials, and I think that's the case with these
20 measures certainly. There are studies and
21 systematic reviews -- including two recent ones
22 that I have here with me -- on medication

1 reconciliation interventions, including
2 pharmacist-related hospital staff education and
3 IT-focused interventions.

4 However, these interventions are
5 beyond the scope of this measure, as this measure
6 does not include elements related to pharmacy or
7 pharmacist-based interventions or IT-based
8 interventions. They're very broad measures,
9 hopefully for the implementation in a broad
10 variety of facilities.

11 They are different than many of our
12 other measures in that we tend to develop
13 measures for physical level reporting and
14 accountability programs, and usually with those
15 measures we bring back PQRS data or other types
16 of data that will hopefully show a progression, a
17 positive progression on the performance on these
18 measures.

19 However, these being facility-based
20 measures, as you all noted in the comments and
21 during our previous call about two weeks ago, we
22 do not have a robust implementation for these

1 measures yet. And, as Marcia was mentioning, we
2 do try to bring -- for maintenance of measures,
3 we do try to bring data showing the progression
4 of these measures and the performance, and
5 hopefully that it's changed.

6 That is not the case with these
7 measures. Some of them have been picked up in
8 programs. However, we do not yet have the data
9 for those. The expert work group felt that these
10 measures that are before you today, all four of
11 them, the next ones that we'll discuss, represent
12 a fundamental step in improving elements of care
13 transitions, and we certainly heard the standing
14 committee during the initial care and within your
15 comments that you provided, about the limitations
16 of these measures including, as I mentioned, the
17 evidence base.

18 But we do have a process whereby our
19 expert work groups can address these as part of
20 the iterative measure maintenance and update
21 process. So that's something that we're
22 certainly here to listen to your additional

1 concerns about these measures, and then see.

2 As they stand right now, we have them,
3 but certainly at a later point maybe get together
4 regardless of what happens here with the
5 endorsement of these measures, get together with
6 our expert work group and try to improve upon
7 these measures because bottom line, we want to
8 make sure that care transitions are improved and
9 patients have the information they need.

10 So for Measure 647, one of the
11 concerns was also that we didn't have sufficient
12 gap data or updated gap data. So I was able to
13 find gap data for many of these measures, and
14 I'll present them for each measure during the gap
15 discussion.

16 So this first measure, Reconciled
17 Medication List Received by Discharged Patients.
18 Basically it assesses the discharges from an
19 inpatient facility, and that patients or their
20 caregivers received a reconciled medication list
21 at time of discharge, including medications to be
22 taken or medications not to be taken by their

1 patient --

2 CO-CHAIR LAMB: Can I ask you to hold
3 the extra data --

4 MS. CHAVARRIA: Yes.

5 CO-CHAIR LAMB: --- until we get to
6 that specific review, and then we can ask you to
7 share that with us?

8 MS. CHAVARRIA: Absolutely,
9 absolutely.

10 CO-CHAIR LAMB: That way we'll go
11 through kind of a standard review.

12 MS. CHAVARRIA: Okay. So I'll just
13 provide a quick rationale, and then the
14 exclusions are patients who died and patients who
15 left against medical advice, which was one of the
16 concerns as well.

17 (Off-mic comment.)

18 CO-CHAIR LAMB: Okay. Just to draw to
19 your attention -- there we go. PCPI measure
20 developers did share additional reliability data
21 with us after the call. You all should have
22 gotten that. No? Okay. So that will be part of

1 this review. So we're going to move into the
2 review then of 646. Chris, you're taking lead?

3 MEMBER DEZII: Yes ma'am.

4 CO-CHAIR LAMB: If you would start us
5 off?

6 MEMBER DEZII: Right. Thank you.
7 I'll follow my script here. This is 646, the
8 measure number. The title is Reconciled
9 Medication list Received by Discharged Patients.
10 Discharge is from an inpatient facility to home,
11 self care or any other site of care. It's a
12 reconciled list to the patients, not the
13 facilities.

14 The description is the percentage of
15 discharges from an inpatient facility, hospital
16 or inpatient or observation, skilled nursing
17 facility or rehab facility.

18 It's a home for any other site of care
19 in which the patient, regardless of age or their
20 caregiver, received a reconciled medication list
21 at the time of discharge including, at a minimum,
22 medications in the specified categories. The

1 level of analysis is facility and integrated
2 delivery systems.

3 Getting to the evidence, this is an
4 NQF-endorsed measure undergoing maintenance
5 evaluation. It is a process measure. The
6 evidence, the evidence is a bit dated in my
7 opinion. It's from, however, still important and
8 relevant. It's from a 2006 Transitions of Care
9 Consensus Conference. It's essentially a
10 standard of care conference by the American
11 College of Physicians, the Society of General
12 Internal Medicine and the Society of Hospital
13 Medicine, that had an output from the consensus
14 conference with a set of eight standards.

15 One of those standards is a reconciled
16 medication list. So you know, I'll call that a
17 standard of -- well, I'll call that a standard of
18 care. They propose the minimal set of data
19 elements that should always be part of the
20 transition record, such as principle diagnosis
21 and problem list, medication list, test results,
22 pending results, medication reconciliation,

1 standard of care, a performance metric
2 constructed to facilitate, enable -- to enable
3 the standard as useful.

4 Now the evidence is based on the NQF's
5 measure maintenance policy. This evidence is
6 considered a pass. If the Committee agrees the
7 evidence basis for the measure has not changed --
8 and the measure developer tells me that the
9 evidence really hasn't changed, right? There
10 isn't anything more. There may not be a need for
11 a repeat discussion and vote on the evidence.

12 Now we probably -- I don't know if
13 we're going to vote on this, but we should
14 probably talk about it, because this is the
15 evidence base for all the other measures too,
16 okay? So now the comments I got from my
17 colleagues, and I must -- I guess I have to admit
18 that I had some technical difficulties and I have
19 my whole opinions here without seeing what the
20 rest of my committee had to say or the group that
21 I'm with.

22 But, you know, pretty much identify

1 that the evidence is weak, insufficient.

2 However, I mean and in its present state, it does
3 rise to the level of pass for the NQF. It's part
4 of me, part of me wonders why there has been no
5 movement in evidence development since 2006.

6 What is it, 2017 right? I mean, okay. Sorry.
7 I'm getting old.

8 You know, and that's part of the gap
9 that I didn't get to say, but I guess since I
10 have the floor, I'll take it. I mean the paucity
11 of evidence that comes out of the measure space
12 to date is pretty remarkable I think. All right.
13 I don't mean -- I sound like I'm beating up on
14 the measure and I'm not. Maybe I am. Do you
15 have any comments about what I just said about
16 the evidence for this measure?

17 MS. CHAVARRIA: So it is. It is an
18 issue because again, these are broad measures,
19 and this is what the expert work group thought
20 was a gap in care that needed to be addressed.
21 We do have consensus policy statements from 2009,
22 the TOCCC.

1 MEMBER DEZII: Yeah.

2 MS. CHAVARRIA: And unfortunately in
3 some of the reviews, the systematic reviews that
4 I do have, they're always calling for improved or
5 more robust studies around this, this area. So
6 it really is an issue that needs to be studied
7 more, and there is a paucity of data at this
8 point.

9 MEMBER DEZII: Yeah, yeah. Now I
10 agree. I mean empirically we all know that this
11 is an issue, and this is where I started my
12 concept of the bridge, you know. This measure is
13 necessary to be able to, you know. The next
14 measure you developed. Do you develop primarily
15 measures or just do maintenance measures?

16 MS. CHAVARRIA: No. We haven't
17 developed new ones, but that's part of our work
18 plan.

19 MEMBER DEZII: Okay, okay. This
20 measure matters when we know the impact of what
21 it is we've done with this measure, as well as
22 the other measures. So you know, I hope that

1 we're not still referring to the 2006 Transitions
2 of Care evidence three years from now. All
3 right. Oh, I sound like a hard guy.

4 CO-CHAIR LAMB: Chris, so to summarize
5 then, basically the evidence has not changed.
6 We'd like to see evidence down the road.

7 MEMBER DEZII: Correct.

8 CO-CHAIR LAMB: Let me just open it
9 up. I don't think your two co-reviewers are
10 here. Marcia, I think, was taking a plane and
11 I'm not sure if Colby ever got on. No? Okay.
12 So I guess Chris make a recommendation, because
13 the evidence has not changed. As you were
14 saying, we don't necessarily have to review that
15 or vote on it again. Do you have a
16 recommendation?

17 MEMBER DEZII: I have a recommendation
18 that we -- now when we're talking our evidence,
19 is performance gap a different discussion? Okay.
20 I move that we -- I see no need to further -- I
21 was going to beat this dead horse, but discuss
22 this evidence right now, and move that we move

1 on.

2 CO-CHAIR LAMB: Let's open that up for
3 discussion, so that Chris is recommending that we
4 just move forward, that we do not vote on it and
5 the evidence is what it is right now. Comments?
6 Ellen.

7 MEMBER SCHULTZ: I would second that.
8 I mean I've spent a lot of time digging through
9 care coordination literature and there are more
10 gaps there even perhaps than around measurement.
11 So I think at least having strong expert
12 recommendations is something as a basis, and I
13 wouldn't expect that the importance of medication
14 reconciliation has changed dramatically in the
15 last decade.

16 CO-CHAIR LAMB: Rich.

17 MEMBER ANTONELLI: So I am struck by
18 how long this has been fielded and effective.
19 There's no new evidence, and then there's a
20 parallel huge body of work, and that is
21 meaningful use that included med reconciliation.
22 I, you know, want to just ask, you know, can we

1 learn anything? Is there anything that came out
2 of the meaningful use experience that even could
3 potentially cross over into this to provide
4 evidence, because I --

5 You know, I'm looking at two separate
6 processes, and is there an inkling of something
7 positive that's come out of either of them?

8 MS. CHAVARRIA: Unfortunately, I'm not
9 sure. We'd have to do some digging and to find
10 whether the parallels are close enough to be able
11 to make some decisions or some consideration on
12 that, but do you guys have anything else?

13 MS. GRAY: Yeah. I think that's a
14 great suggestion, to look at the medication
15 reconciliation measure within meaningful use.
16 When we request data from CMS for meaningful use
17 and PQRS MIPS, we generally only request data for
18 the measures that we steward.

19 So I'm not sure if we would be able to
20 get that data. If we can, I think it would be,
21 you know, really helpful and valuable to perform
22 an analysis of that data and try and, you know,

1 apply that because it is related.

2 MEMBER ANTONELLI: Just a follow-on,
3 and maybe this gets parking lotted when we get to
4 the piece about harmonization. But this one for
5 me is aching for a conversation about, you know,
6 parsimony and harmonization. How does this
7 relate to meaningful use? Do we need this
8 measure? Is it better because it's patient
9 directed versus EHR-based?

10 But so those are the two points that
11 I would raise about this, the first one relating
12 to the paucity of evidence, even after this many
13 years.

14 CO-CHAIR CASEY: Yeah. So I -- I
15 don't know if you can see the screen, but I --
16 and I was sorry I wasn't on this call. But I
17 found two systematic reviews. It wasn't clear
18 from the documentation whether what you were
19 referencing that's now over ten years old was
20 even based upon an explicit evaluation of
21 evidence.

22 I was dismayed as a PCI member to see

1 that you didn't have those two references, one
2 from Archives which is cited here, which shows
3 that there's a paucity of rigorously designed
4 studies comparing -- this is inpatient now,
5 inpatient med rec practices on outcomes, right.

6 And there are no high quality studies.
7 This other one was just published last year in
8 BMC Medical Informatics and Decision-Making,
9 again showing the same types of things, you know,
10 that it minimized unintended discrepancies but it
11 couldn't link it to any outcomes of safety or
12 harm or anything.

13 So while I like the idea of med rec,
14 I mean I go to my own doctors and I have to tell
15 you, even in one Epic system, I've never seen my
16 providers get my meds right once. So I'm just
17 saying that I have a lot of skepticism, so I'll
18 just leave it at that.

19 MS. CHAVARRIA: I do have two
20 systematic reviews from the -- they're from 2013,
21 and I think it's the one that you mentioned, and
22 what they've looked were studies again that were

1 -- we are talking about a measure where the
2 medication reconciliation documentation was
3 provided to the patient, and the patient then can
4 take that information and make sure that they
5 adhere to it.

6 These were studies done, whether
7 pharmacy-related, IT-related. There were others
8 with follow-up about five days after the
9 discharge, follow-up from staff at the hospital.
10 So these were kind of different types of
11 interventions, and whether that in fact improved
12 outcomes with a patient.

13 But it did not speak specifically
14 about providing the education necessarily, just
15 in med rec listing to the patients. So these are
16 beyond with elements -- let's say we developed
17 one where our pharmacy transitioned records or
18 medication reconciliation lists better than
19 others. But certainly we would be able to use
20 this and provide this type of information.

21 CO-CHAIR CASEY: Well if I may, you
22 know, and again I'm a proponent of this measure,

1 but what is missing you mentioned education,
2 which is not just here's your list, right? It's
3 what is this for, what good does it do me, is
4 there a cheaper drug I can take, right? And I
5 don't think any of these questions get asked in
6 this.

7 Plus it's like here's your list, see
8 you later. That's what happens in practice,
9 right?

10 MS. CHAVARRIA: Yeah.

11 CO-CHAIR CASEY: I know, because I've
12 got sheets of these things at home. So I'm -- as
13 you can tell, I'm pretty emotional about this.
14 But you mentioned education, and I don't see that
15 here.

16 MS. CHAVARRIA: No absolutely, and
17 this --

18 CO-CHAIR CASEY: So I'm just -- this
19 is probably more feedback for the future, but
20 you're way short of where you need to be on this.

21 MS. CHAVARRIA: Yes. I think you
22 might be talking about --

1 CO-CHAIR CASEY: Sounds like on C-SPAN
2 interviewing Trump candidates, you know, but
3 whatever.

4 MS. CHAVARRIA: Like a patient
5 reported outcome measure perhaps at some point.
6 But again, this is not where we are with this
7 measure at this point.

8 MEMBER DEZII: That's why I
9 articulated the word "reconciled." I mean
10 there's, you know, it's -- the measure is the
11 delivery of a reconciled list, you know. It's
12 like that old thing, you know. You put something
13 here, a miracle occurs and then you have
14 something here. The reconciliation process
15 really is not -- it's not discussed or mentioned
16 here.

17 CO-CHAIR LAMB: Rich.

18 MEMBER ANTONELLI: So Chris, can I
19 politely challenge you to justify why we
20 shouldn't vote on the evidence for this measure
21 at this point?

22 MEMBER DEZII: Well, the reason I

1 suggested that is because as it's constructed, it
2 does and NQF has new evidence-based hurdles, is
3 that it passed their hurdle. That's --

4 MEMBER ANTONELLI: But this Committee
5 has to serve its function, which doesn't
6 necessarily mean that whatever the staff says we
7 have to go along with. So I guess I'm just --
8 and by the way, there's a cardiac surgeon in
9 Boston that says I have no dog in this fight, and
10 I don't have a dog in this fight although I hate
11 that expression.

12 But I am concerned with the sentiment
13 that I'm hearing, that we should just jump over
14 and not vote or at least have a little bit more
15 vigorous debate about justifying why we wouldn't
16 vote. I'm sensing a lot of dystonia here.

17 MEMBER DEZII: Agreed.

18 CO-CHAIR LAMB: Elisa.

19 MS. MUNTHALI: So you are right. I
20 think Chris said it. You do not have to take our
21 recommendations. They're just our preliminary
22 look at the submission as staff sees it, just a

1 recommendation. However, while this measure did
2 pass evidence, was it 2008 when it was first
3 brought forward or -- it was a while ago, we have
4 since changed, you know, our evidence rating.

5 I hear there's quite a bit of
6 struggle. It doesn't sound like there is
7 consensus on where you want to go. A staff
8 recommendation from me would be for you to vote
9 on it. One of the concerns you have is about the
10 insufficient evidence. We do have a pathway,
11 recognizing that some measures may not have
12 systematic reviews or the body of evidence that
13 other measures may have.

14 So if you do vote for an exception to
15 the evidence, insufficient evidence with an
16 exception, that is a pathway. It will go forward
17 through the evidence criteria and go to
18 performance gap and all the rest. It wouldn't
19 fail, but you must vote -- if you do that
20 insufficient, a low vote would fail this measure.
21 So I hope that makes it clear.

22 We didn't have that before when this

1 measure came forward to you, so that's why it
2 doesn't say previous vote insufficient with
3 exception.

4 CO-CHAIR LAMB: Elisa, may I ask,
5 because I was going to recommend we take a vote.
6 I think there's enough question in the room. Is
7 "with exception" one of our options?

8 MS. MUNTHALI: So you'd have to go
9 through insufficient. So Yetunde, perhaps you
10 can pull up the algorithm first and I think
11 everyone has a copy at your desk, and this would
12 be the evidence algorithm. It's the first one
13 you see.

14 CO-CHAIR LAMB: I should pull it up
15 too. I actually can't see anything over there so
16 -- it's a little small.

17 MS. MUNTHALI: So we would walk down
18 the first boxes, the green box as a measure,
19 assess the performance on health outcome. It's
20 now obviously this is a process measure. The
21 blue, we'd follow the algorithm down to three.
22 We'd go to the seven, which is the purple. Is

1 empirical evidence submitted but without
2 systematic review and grading of the evidence,
3 and it's no.

4 So then we go to the next page, and
5 this is where we land. Are there or should there
6 be performance measures of a related health
7 outcome or evidence-based intermediate clinical
8 outcome or process? If you voted no, then you'd
9 go to your right to Box 11. Is there evidence of
10 a systematic assessment of expert opinion, that
11 the benefits of what is being measured outweigh
12 potential harms.

13 If that is yes, then you go to the
14 next box, which is 12, and does the steering
15 committee here, and this is a standing committee,
16 agree that it is okay or beneficial to hold
17 providers accountable for performance in the
18 absence of empirical evidence of benefit to
19 patients, and there's some considerations that
20 are in the -- that are listed there, and if you
21 said yes, then we would rate it as insufficient
22 evidence with exception.

1 Just wanted to walk you through how
2 you would land at that decision point. So
3 Yetunde, if you pulled up the voting slides, what
4 it would give you is a rating of 1 high, 2
5 moderate, 3 low and 4 would be insufficient. You
6 would have to vote insufficient.

7 Then we'd take you to another slide
8 that says do you agree that the benefit -- it's
9 okay to hold providers accountable for
10 performance in the absence of empirical evidence.
11 So that would be the insufficient evidence with
12 exception.

13 So there are two different slides, but
14 you have to land on insufficient. A low would
15 fail the measure. So I just wanted to clarify
16 that.

17 CO-CHAIR LAMB: Does anybody have
18 questions about that before we vote? Don.

19 CO-CHAIR CASEY: Elisa, I just want to
20 be certain I understand the specifics here. The
21 measure developers submitted their measure specs
22 with the evidence, and we enhanced that. So are

1 you talking about this in the context of just
2 what the measure developers have done, or does it
3 include what we've been able to identify, even
4 though it's not part of the measure submission?

5 MS. MUNTHALI: So what they submitted,
6 did you just submit it now? If you're
7 considering it now, you wanted to update your
8 submission with this additional evidence. Then
9 the Committee would have to decide whether or not
10 that's sufficient.

11 The additional information that you've
12 brought forward, that is -- it's good context,
13 and perhaps that's something you can look for,
14 and during the post-comment call make sure you
15 have that information updated in your submission.

16 So it would be -- if it didn't go
17 forward and people really felt that there is
18 evidence out there; however, your submission does
19 not contain that information, the Committee would
20 probably vote low and the measure would fail.

21 But you can come back during the
22 commenting period with this additional evidence.

1 I hope that clears it up.

2 CO-CHAIR LAMB: Is everybody ready to
3 vote? Terry?

4 MEMBER O'MALLEY: Just a
5 clarification. So if we were to vote
6 insufficient, and sufficient numbers of us voted
7 that way, we would pass -- we would move this
8 beyond evidence to the next consideration.

9 MS. MUNTHALI: Then you would have to
10 decide whether or not you would want to invoke
11 the insufficient with exception.

12 MEMBER O'MALLEY: Right, so and then
13 we'd have to invoke that and then move to the
14 next slide.

15 MS. MUNTHALI: Yeah, then you move to
16 the next.

17 MEMBER O'MALLEY: If we voted anything
18 else that didn't get it to pass, then it would
19 fail the evidence and fail as a measure?

20 MS. MUNTHALI: Yes. So essentially
21 it's low, majority voting low.

22 MEMBER O'MALLEY: Yeah, okay. So the

1 choice is vote low and the measure doesn't go
2 forward, or vote insufficient and then we get to
3 decide whether that's sufficient?

4 MS. MUNTHALI: I mean it's -- what's
5 complicating it is we have additional information
6 that was brought forward to you today. It is not
7 part of the submission that you reviewed, but we
8 recognize it's there. There's still an
9 opportunity for the developers to work on the
10 measure, update the measure with the additional
11 evidence and bring it forward to you for a final
12 decision.

13 CO-CHAIR LAMB: Elisa, I have to ask
14 a question then. Just so that if we -- I
15 understand if we all vote insufficient, that can
16 they then bring it back or it ends it right
17 there?

18 MS. MUNTHALI: No. If you vote
19 insufficient, then we would ask you the question
20 of whether or not you want to invoke the
21 exception.

22 (Off-mic comment.)

1 MS. MUNTHALI: If you don't, then it
2 dies there and they can come back with the
3 additional --

4 (Off-mic comment.)

5 CO-CHAIR LAMB: Is everybody perfectly
6 clear on that? Okay.

7 MEMBER ANTONELLI: You were just
8 shutting your microphone off. Did you say that
9 it can come back? Okay, thank you.

10 MS. MUNTHALI: Yes.

11 CO-CHAIR LAMB: Okay.

12 MEMBER HOHL: Oh, I'm sorry. Could
13 you just review again the difference if we vote
14 low?

15 MS. MUNTHALI: So if you vote low,
16 you're saying that the quality of the evidence
17 there is, it's low. It's not good quality. If
18 you're saying insufficient, you're saying that
19 you know that there is additional evidence out
20 there or there's evidence out there that probably
21 hasn't been included in the submission.

22 So you would then say well -- or you

1 might be saying that there's not enough evidence
2 in this area. So it gets you to two different
3 decision points. It can potentially get you to
4 two different decision points. Low would
5 definitely kill it right now. Insufficient may
6 give you an opportunity for the measure to
7 survive today.

8 But it can come back also once you
9 have considered the Committee's recommendations
10 and also the additional studies that they've
11 presented to you today.

12 MEMBER HOHL: Okay, thank you.

13 CO-CHAIR LAMB: Ready? Any other
14 questions? Okay. Yetunde.

15 MS. OGUNGBEMI: We are now voting on
16 the evidence for Measure 0646, Reconciled
17 Medication List Received by Discharged Patients.
18 Your options are 1 high, 2 moderate, 3 low and 4
19 insufficient. Voting is open.

20 [VOTING.]

21 MS. OGUNGBEMI: Results are 0 votes
22 high and moderate, 1 vote low and 15 votes

1 insufficient. 0 percent high, 0 percent
2 moderate, 6 percent low and 94 percent
3 insufficient. So we will move on to voting on
4 the empirical evidence with exception, or if you
5 want to vote on that.

6 (Pause.)

7 MS. OGUNGBEMI: So we are now voting
8 on the potential exception to empirical evidence
9 for Measure 0646. Your options are 1
10 insufficient evidence with exception and 2, no
11 exception.

12 CO-CHAIR LAMB: Before we vote, don't
13 vote yet please. I just want to be clear on
14 this. If we do no exception, it still can come
15 back?

16 MS. MUNTHALI: Yes.

17 CO-CHAIR LAMB: And if we do
18 insufficient with exception, we just move on?

19 MS. MUNTHALI: Yes.

20 CO-CHAIR LAMB: Okay. So the
21 difference is timing, is that correct?

22 MS. MUNTHALI: It's timing.

1 CO-CHAIR LAMB: Okay. So if we move
2 insufficient evidence with exception, we're going
3 to go through the rest of the review now. If we
4 say no exception, then the measure developer,
5 PCPI, can bring it back to us, and then we would
6 go through the rest of the review. Did I get
7 that correct?

8 MS. MUNTHALI: Yes. So it would
9 essentially fail if you said no exception.

10 MS. OGUNGBEMI: Voting is open. If
11 you press something that you did not mean to
12 press, just press another button.

13 [VOTING.]

14 FEMALE PARTICIPANT: Can you review
15 again the options there?

16 MS. OGUNGBEMI: Yes. 1 is
17 insufficient evidence with exception and 2 is no
18 exception.

19 [VOTING.]

20 MS. OGUNGBEMI: Results are 13 votes
21 insufficient evidence with exception and 3 votes
22 no exception, 81 percent insufficient and 19

1 percent no exception. So we will move on to
2 performance gap.

3 CO-CHAIR LAMB: Thank you everybody.
4 Very thoughtful discussion. I think we will
5 probably have similar ones on the other three
6 measures, so hopefully we all understand the
7 options now. Okay, so Chris.

8 MEMBER DEZII: Good input everyone.
9 We'll have as much fun here in the performance
10 gap, because frankly there is no information on
11 performance. It's the evidence is -- well,
12 there's no information provided. There's no new
13 data, and I think you were very -- you indicated
14 there really aren't any performance scores here.
15 So performance gap is insufficient. I can go on
16 and on and on, but I won't, unless the developer
17 can fill a gap there.

18 MS. CHAVARRIA: Yes, I do.

19 MEMBER DEZII: What's your name?

20 MS. CHAVARRIA: It's Elvia.

21 MEMBER DEZII: Elvie, I'm sorry.

22 MS. CHAVARRIA: No problem, no

1 problem. So while we did provide some
2 information you -- and it's from the CDC, in that
3 they did provide quite a bit of information --
4 and we did provide it in the submission -- that
5 adverse drug events result in 700,000 emergency
6 department visits and 120,000 hospitalizations
7 each year.

8 So then there's a gap in terms of the
9 results of not providing maybe some information,
10 or maybe other things too, but at least certainly
11 somewhat related. Now the issue here is that the
12 CDC also, as you see in your information that you
13 have before you, that the CDC does expect these
14 numbers to increase, due to not only the
15 polypharmacy that we have -- are seeing now and
16 increasingly aging American population and
17 development of new medications.

18 So what I did is to try to really get
19 at the issue and not provide gaps that maybe are
20 not directly related to what we're trying to
21 measure, which is I think where the issue lies.
22 But we do have some additional information, and

1 that's from the Wong article. We did provide
2 that, and I think the concern was it was older
3 information, that 71 percent of patients had at
4 least one actual or potential unintentional
5 medication discrepancy.

6 And then incomplete prescription
7 requiring clarification and causing a delay in
8 obtaining medication was 50 percent, and the
9 omission of medications occurred in 23 percent of
10 cases, and those were the most common
11 unintentional discrepancies. So we did provide
12 that.

13 However, we do want to provide
14 additional evidence, and it includes one small
15 study, a 2013 study in the Journal of Hospital
16 Medicine, which found that of the study patients,
17 50.6 percent experienced medication
18 discrepancies. And here we did find that males
19 were 4.34 times more likely to have a
20 discrepancy. So it seems like there is some
21 difference there at least related to gender.

22 And then, again, the systematic

1 reviews, and Dr. Casey, you mentioned one of
2 them. They do provide information about
3 medication reconciliation strategies. In the
4 review of the studies that they looked at, they
5 did find a medium proportion of unintended
6 discrepancies across interventions, and this is
7 including the pharmacy-related or the IT-related
8 or the staff education.

9 They found the discrepancies at 34
10 percent across the different types of strategies
11 that were implemented.

12 CO-CHAIR LAMB: Thank you. Comments.
13 Rich.

14 MEMBER ANTONELLI: Everything that you
15 just said totally resonates, but I'm not seeing
16 the connection between this measure and any
17 evidence that suggests that it is effective in
18 ameliorating any of those gaps. Is there
19 anything that you could --

20 MS. CHAVARRIA: Yeah. So we usually
21 -- again, unfortunately that's another issue that
22 this Committee will need to determine. We do

1 usually tend to provide PQRS data for that, and
2 then it will show, you know, 93 percent or 50
3 percent, etcetera, and those are for our
4 physician level measures.

5 This has been a little bit of a
6 different beast in that these are facility
7 measures, and we've had more difficulty in
8 getting these implemented, unfortunately. So our
9 intent every time is to bring such performance
10 scores and performance data, and NQF staff will
11 attest to that, we do. Scout's honor. But in
12 this case, that was just not available, and we
13 didn't want to bring information that would
14 obfuscate the -- what we're really trying to get
15 to here.

16 CO-CHAIR CASEY: So again as a -- I
17 will say that the difference between an error and
18 an adverse drug event is night and day. Errors
19 occur over here and adverse drug events occur
20 over here, and empiric evidence shows that the
21 intersection of the two is about three percent,
22 knowing that it's hard on both sides to measure

1 in a standard way what we're talking about.

2 So I just want to point out to the
3 Committee that we shouldn't, in my opinion,
4 conflate medication errors with adverse drug
5 events. I mean they're related but different
6 issues, and so this seems to me to be focused a
7 lot more on the error side, with the hope that
8 you'll have a barrier to preventing adverse drug
9 events.

10 But I think the way this gets
11 operationalized is, again, here's the list, see
12 you later, and I don't think there's enough in
13 between, as you know. So it's just a nuance that
14 I think is important here.

15 MS. CHAVARRIA: I do want to add if I
16 may that -- and my colleague here just reminded
17 me, that while our physician level measures are
18 implemented and the facility level ones may not
19 be, we did -- they are just now being implemented
20 in the prime. It's a CMS Medicaid-related
21 program, and this is in California.

22 They just implemented it last year and

1 it was last year was a pay for reporting, but now
2 we're going to switch over to pay for
3 accountability, and we should have data. Whether
4 they share it with us hopefully they will,
5 because this is -- we are the stewards and
6 developers of this measure. We expect to be able
7 to have that data in hand. But I'm not sure what
8 the timing for that will be.

9 MS. GRAY: The timing for CMS data
10 becoming available to measure developers is
11 typically -- it's on a two year delay. So for
12 this year if we were submitting physician level
13 measures, we would receive 2015 data, just to
14 give you an idea.

15 MEMBER DEZII: For completeness, I
16 don't think -- there wasn't any disparity
17 information either, right?

18 MS. CHAVARRIA: No. Just the one that
19 I was able to find, in that males were 4.34 times
20 more likely to have a discrepancy. But again as
21 Dr. Casey mentioned, it's not directly related to
22 that. But in terms of we looked for whether

1 there was a gender, racial, ethnic types of
2 disparities, and there was no information related
3 to that.

4 CO-CHAIR LAMB: Any other comments
5 before we take a vote on opportunity for
6 improvement?

7 (No response.)

8 CO-CHAIR LAMB: Okay. Yetunde.

9 MS. OGUNGBEMI: We are now voting on
10 performance gap for Measure 0646. Your options
11 are 1, high; 2, moderate; 3, low; and 4,
12 insufficient. Voting is open.

13 [VOTING.]

14 MS. OGUNGBEMI: Results are 0 votes
15 high, 3 votes moderate, 4 votes low and 9 votes
16 insufficient. 0 percent high, 19 percent
17 moderate, 25 percent low and 56 percent
18 insufficient. Measure 0646 fails performance
19 gap.

20 MS. MUNTHALI: So evidence is the only
21 criterion that has the insufficient with
22 exception. So we counted the two low, low and

1 insufficient, those are grouped together. So
2 that is a fail. The majority, over 60 percent of
3 the Committee voted either low or insufficient.

4 CO-CHAIR LAMB: Given the looks on
5 your faces, let's step back a minute because that
6 vote means that the measure does not go forward,
7 okay. That's the stopping point on the measure.
8 It's unlike the one we just did, where the
9 measure developers can come back. Do we have an
10 option of rethinking or are we done?

11 MS. MUNTHALI: You mean rethinking the
12 vote?

13 CO-CHAIR LAMB: Revoting.

14 MS. MUNTHALI: Revoting. So ---

15 CO-CHAIR LAMB: --- if everybody wants
16 to do that.

17 MS. MUNTHALI: Did you have the same
18 understanding of insufficient as you did with
19 evidence?

20 CO-CHAIR LAMB: Did everybody
21 understood that if we voted insufficient, this
22 did not go forward? Yes.

1 MEMBER BECKWITH: Does anyone wish to
2 change their vote based upon the information --

3 MS. MUNTHALI: We can take -- we can
4 revote. We'll be fine.

5 CO-CHAIR LAMB: Yeah. Let's do the
6 revote, just to be sure. Everybody's clear now
7 that if you vote insufficient, okay, it stops --
8 or low. Those two get combined. So everybody
9 ready, everybody clear on the implications. All
10 right. Everybody's clear. Go.

11 MS. OGUNGBEMI: We're now voting,
12 revoting on the performance gap for Measure 0646.
13 Your options are 1, high; 2, moderate; 3, low;
14 and 4, insufficient. Voting is open.

15 [VOTING.]

16 MS. OGUNGBEMI: Results are 0 percent
17 high, 6 percent moderate -- or pardon me, 0 votes
18 high, 6 votes moderate, 4 votes low and 6 votes
19 insufficient. 0 percent high, 38 percent
20 moderate, 25 percent low and 38 percent
21 insufficient. So the measure still fails.

22 CO-CHAIR LAMB: Okay. We're going to

1 move on then to the next measure. All right. We
2 are moving now to 647, also PCPI, and Samira, are
3 you first on --

4 MEMBER KOPLEFF: A quick ask. Could
5 we take two minutes to hear from other Committee
6 members, and I certainly had one point that I
7 wanted to make regarding the other criteria. We
8 gave that same benefit to our previous measure
9 this morning, when we failed on the reliability
10 criteria.

11 We still sort of followed due process
12 to give the developer the input related to other
13 criteria. So may I --

14 CO-CHAIR LAMB: Yes, we can do that
15 Emma. So Chris, do you want to just give us the
16 review on the other criteria, reliability,
17 validity and so forth?

18 MEMBER DEZII: We did get additional
19 testing. The original submission had an overall
20 score for data element testing, rather than a
21 score for the numerator, denominator and
22 exclusions, and only a single kappa value was

1 reported and this was insufficient. They since
2 have come back, frankly.

3 I guess it's additional testing, but
4 the bottom line is that that was so powerful that
5 the numerator, the denominator and the exclusions
6 were 100 percent. Therefore, there was no
7 additional execution of the test because you
8 can't divide by zero. Is that correct? Okay.

9 Which -- which is fine. I mean from
10 a testing standpoint, that's acceptable. That's
11 acceptable. Validity --- or wait. Do we just
12 stay on reliability? I mean it's -- the measure
13 specified, the specifications are specified for a
14 facility. Unit of measurement is discharges
15 rather than patients. That's a little change.

16 The numerator includes all instances
17 of discharges. The denominator includes all
18 discharges of patients regardless of age from an
19 inpatient facility. The exclusions include
20 patients who die and who left AMA. The measure
21 is not risk adjusted. I think the data elements
22 are defined.

1 The data from a report ---
2 automatically generated report from an EHR was
3 compared to manual extraction of patient records,
4 to calculate parallel forms of reliability for
5 the measure, and that's for the -- well, it's all
6 I have to say. I mean from a reliability
7 standpoint, with the additional testing it moved
8 to -- from insufficient to -- is this a pass?
9 This isn't a pass/fail is it? No.

10 CO-CHAIR LAMB: We don't need to worry
11 about that now.

12 MEMBER DEZII: Oh okay.

13 CO-CHAIR LAMB: Any other comments on
14 reliability?

15 CO-CHAIR CASEY: I just had a
16 question. I had a question about whether these
17 data on inter-rater reliability had been upgraded
18 since the '08 submission, and did it include
19 testing inter-rater reliability in the electronic
20 environment, which is where this has gone. So
21 just a technical question that you might want to
22 clarify.

1 MS. GRAY: Great question. So this is
2 the same testing data that we previously
3 submitted. It's not from 2008 though; the
4 testing projects span from 2009 to about 2011,
5 including some alpha testing and some, you know,
6 focus groups. A lot of the timeline was focused
7 on the focus groups, because that was six
8 different sites that we used.

9 But the reliability data is from the
10 one site and the automated report was compared to
11 a manual abstraction of an EHR, and that's what's
12 been submitted here. Yes, sure.

13 CO-CHAIR LAMB: Ellen.

14 MEMBER SCHULTZ: Yes. As long as
15 we're giving some feedback, I have to say I was
16 having a real hard time being convinced about
17 reliability from just one single site. And then
18 if this is designed to be something where sites
19 can do an EHR poll, then I want to see
20 reliability across sites. Can they even
21 implement that guidance to be able to pull from
22 the EHR, and so that will be something to think

1 more about if this is a measure you're going to
2 continue to work on.

3 It sounds like there are plans that
4 are starting to be put in use hopefully, that
5 there will be much more data that you can rely on
6 to look carefully at both the reliability and the
7 validity across sites.

8 MEMBER O'MALLEY: This is probably
9 more a validity comment than a reliability
10 comment, although they're merged, and that's sort
11 of, where did this list of data elements that's
12 part of a transition record come from
13 specifically?

14 Why didn't it come from a group of a
15 ED users, who would then tell you what it is they
16 wanted to know after they left the ED, rather
17 than the clinicians who figured out what they
18 wanted to do know? Oh I'm sorry, this is the
19 inpatient right, not the ED. But the same point,
20 same point, the same point. It doesn't matter
21 who.

22 CO-CHAIR LAMB: Chris, if you would,

1 did you want to --

2 MS. GRAY: I just wanted to clarify
3 what the question was. Was it -- were you asking
4 how the data elements were identified initially,
5 or if it was vetted? Okay. So the technical
6 expert panel, I don't have the original
7 composition in front of me.

8 (Off mic comments.)

9 MS. GRAY: Oh okay. Then never mind.

10 CO-CHAIR LAMB: Chris, as you go
11 through validity and feasibility and usability,
12 if you could just hit the high spots of comments
13 that we want to share with the measure developer.
14 You don't need to go through the whole review.

15 MEMBER DEZII: You know, established
16 by the technical expert panel 11. I think there
17 was a fair, a reasonable concordance there,
18 though I guess your data elements from one -- if
19 it's from one site. So it had, you know, it had
20 face validity with the supporting -- with
21 supporting reliability metrics done. I mean I
22 don't know.

1 (Pause.)

2 MEMBER DEZII: Exclusions are
3 consistent with the evidence and there's no risk
4 adjustment. But of course then you don't know
5 how the exclusions affect the performance
6 measures. But it had, you know, it had face
7 validity, low to moderate.

8 CO-CHAIR LAMB: Keep going. Just
9 focus on the comments of the developers.
10 Feasibility, usability and then we'll just open
11 it --

12 MEMBER DEZII: Keep going? Oh, all
13 right.

14 CO-CHAIR LAMB: Yeah, and then we'll
15 open it up to everybody.

16 MEMBER DEZII: All right. The measure
17 is coded and extracted by someone other than the
18 person examining the original information. I
19 don't think any data elements are defined fields
20 in electronic sources, though you do, you know,
21 you do recognize that it's a non-traditional
22 approach. You did get some guidance -- I have it

1 here -- you provided guidance on how to address
2 that.

3 So you know, it was -- it was
4 moderately feasible, though you know
5 reconciliation isn't an electronic or automated
6 process. There's, that's, you know, it's highly
7 hands-on and requires clinical review and
8 decision-making. But again, this measure is just
9 the delivery of a reconciled document, without
10 getting into how it gets reconciled. It's still
11 always a question that will get asked.

12 Usability, I mean it's being used
13 right now in the prime hospitals, and we await
14 results from that feedback from that. That's all
15 I have to say.

16 CO-CHAIR LAMB: Thank you. Any other
17 comments for the measure developers on this
18 measure? Emma.

19 MEMBER KOPLEFF: Rich, you mentioned
20 this at the beginning of our conversation about
21 importance, that I was really struck by the
22 information provided around related and competing

1 measures, that there's some higher level
2 discussion to be had. I don't know if it's in
3 the vein of gaps or competing measures or both.

4 But I recognize there's other similar
5 but -- similar measures addressing a similar idea
6 that NQF is reviewing in other places, not
7 necessarily our Committee. I appreciated the
8 developer's comment about looking at this measure
9 specifically through a patient lens, and the
10 patient having that med rec list.

11 Where I struggled was, I feel we today
12 held that measure to a certain level of
13 importance, and you know I think it was the right
14 one. I'm not in disagreement. But we don't have
15 a sense for this Committee of whether those
16 similar other measures are being held to that
17 same sort of challenging thinking.

18 I mean we had to vote and revote to
19 get where we needed to go. So I suppose the
20 general ask is taking a look in an ideal world,
21 whether or not this can happen.

22 The challenge would be for this

1 developer to have some coordinated discussion
2 with some of those other developers, thinking
3 about a measure that not just looks at after
4 discharge whether a reconciled medication list is
5 documented in the record that has just gone home
6 with the patient, but has been verified and, as
7 was mentioned earlier, really reconciled and
8 provided in more than one place to more than one
9 member of the care team, including that patient.
10 Thanks for that.

11 CO-CHAIR LAMB: Emma, I would also
12 suggest, you know, in the recommendations from
13 this Committee, certainly the process of the vote
14 and the reasons will be documented, and I think
15 harmonization now has come up several times
16 related to this particular measure. If we don't
17 get to it today, we will have a discussion about
18 harmonization. Rich.

19 MEMBER ANTONELLI: Under the rubric of
20 trying to derive value, this meets the measure if
21 you can find evidence in the MR that the patient
22 received something. You use the term patient-

1 centered but how cool would it be if this was a
2 patient-reported outcome, for example? You know
3 so what I'm about to make is an editorial
4 statement, and I'm going to own this as a
5 clinician.

6 For those of us that labored under
7 meaningful use, clicking boxes, asking two year-
8 olds if they still smoke cigarettes, etcetera,
9 etcetera, that was really challenging. This,
10 however, could potentially be a whole lot better
11 if the patient could say yes, I received that
12 document and somebody walked through my meds with
13 me.

14 So the way I see this, it's kind of a
15 -- it's sort of a parallel version of MU, but I
16 really love the spirit of it. I think that's why
17 I'm investing as much thought into this as I can.
18 This could really help move things forward. But
19 just another checkbox isn't going to move the
20 field forward. So I would encourage you to think
21 about that.

22 CO-CHAIR CASEY: I went to a Catholic

1 grade school but I quite in 7th grade so --

2 CO-CHAIR LAMB: Before we move on then
3 to 647, I just had recently had the experience of
4 going to my PCP, and I was asked the first
5 question by one of the staff of am I in an
6 abusive relationship. It was the first question
7 I was asked as a new patient, and I looked at the
8 person and said well, I'm not but maybe my
9 husband thinks he is.

10 (Laughter.)

11 CO-CHAIR LAMB: Anyway, talk about ---
12 647, Transition Record, and we're going to move
13 into -- this is a set of Measures 647, 648, 649,
14 all related to transition records and we're going
15 to start with 647. Samira, are you lead? Yes,
16 thank you for reminding me. I keep forgetting.

17 MS. CHAVARRIA: So I'll go through
18 this just quickly, but before I move on, I do
19 want to thank everyone for your thoughtful
20 comments. I appreciate it and we always take it
21 back to our expert work groups and then see where
22 we would go.

1 So for Measure 647, it's a Transition
2 Record with Specified Elements Received by
3 Discharged Patients, and the rationale for this
4 measure was to provide detailed discharge
5 information, which will help patients comply with
6 treatment and follow-up plans, so as not to just,
7 you know, you have been discharged, thank you
8 very much, but actually provide them with a plan
9 that they could follow up, and it does include
10 some elements, minimum required elements for the
11 transition record, and then I will let the lead
12 discussants get into that detail.

13 (Off mic comment.)

14 MEMBER LEATH: So again, this measure
15 is focused on the transition record with
16 specified elements received by discharged
17 patients, and discharges from the inpatient
18 facility to home, self care and any other site of
19 care. My understanding was that there has not
20 been any new updates to this, and that much of
21 the evidence is based on the systematic review
22 and expert opinion of the panel that met.

1 Well, it's here, and that I think one
2 of the things that I do recall reading was that
3 there is currently, and I don't know if I'm
4 saying this in the wrong section, but there's
5 currently studies being done and they're
6 anticipating new data being available by two
7 different sources. So let me stop to see if
8 you'd like to add something.

9 MEMBER BECKWITH: No, except to just
10 comment that as we were looking at this, we
11 really saw this as another process measure and an
12 opportunity to a new word I learned today be a
13 bridge, and have people actually receive some
14 information. I think it's very difficult to know
15 what people have processed.

16 But it seemed as though this
17 information had been updated in 2012. We were
18 going to recommend that a vote didn't need to be
19 taken on whether or not it needed new evidence or
20 whether or not the evidence was sufficient to
21 continue, just to go ahead and go with the path.
22 But I didn't know if you wanted to add anything

1 about new evidence.

2 MS. CHAVARRIA: So I do have some new
3 performance gap evidence that I wanted to share
4 with you, and that again the concern was with the
5 last ones that we provided were from rather old
6 sources. In terms of the -- again, we develop
7 measures based on guideline recommendations,
8 hopefully high level guideline recommendations,
9 but in this case this measure continues to be
10 reliant upon the 2009 Transitions of Care
11 Consensus Policy Statement that was put out by
12 the several groups.

13 There are no new guidelines that would
14 provide support for this measure. So we did
15 provide the same information unfortunately at
16 this point.

17 While I do have performance gap info
18 and then I also have just a little bit of
19 additional info on the implementation of this
20 measure, which I will provide a little bit later
21 because somebody had asked about the
22 implementation of these measures in the inpatient

1 psychiatric facility quality reporting program,
2 and the difference between these two measures and
3 the HBIPS measures.

4 So that's additional information that
5 I have. But again it doesn't necessarily relate
6 to the guidelines.

7 MEMBER BECKWITH: I guess the question
8 then is whether or not the Committee believes
9 that we need to take a vote, or whether we let
10 this information stand and it passes.

11 CO-CHAIR LAMB: Do you want to make a
12 recommendation?

13 MEMBER DEZII: This is the same
14 evidence base that I covered in the last measure,
15 right, complete same?

16 MS. GRAY: It is.

17 MEMBER PACELLA: The previous
18 determination was insufficient with exception; is
19 that correct?

20 MS. GRAY: Yes.

21 MEMBER PACELLA: So the real question
22 do we need to revote, that we think that would

1 come out differently?

2 MEMBER PACELLA: Exactly.

3 CO-CHAIR LAMB: It's a different
4 measure. If we think that's the case, we need to
5 vote. So --- we don't need to vote?

6 MS. MUNTHALI: We could if it's the
7 same evidence. It is the same evidence. We
8 could carry over that vote if the Committee is
9 okay with that, from the prior -- well actually
10 from the prior measure, because it is -- you're
11 saying it's the same vote. So would you -- do
12 you want to vote again or --

13 CO-CHAIR LAMB: Can the reviewers
14 clarify, because the last one was on medication,
15 reconciled medication. Now we're on to
16 transition record. Is it exactly the same
17 evidence that was used for both?

18 MS. CHAVARRIA: It's the same
19 consensus policy statement, because it did
20 provide recommendations that support all of the
21 four measures. So we did provide that as in --
22 as we usually provide the guideline

1 recommendations on which the measures are
2 developed or are based, we provided this document
3 as the supporting guideline. In fact, it's a
4 consensus statement to support these four
5 measures.

6 CO-CHAIR LAMB: Just to go back to
7 your comment, which is, the application is
8 different even though the four are in there. Is
9 that still -- does your recommendation still
10 hold?

11 MS. MUNTHALI: So I'd rather you vote
12 again, and just remember everything we went
13 through with insufficient and insufficient with
14 exception.

15 MEMBER BECKWITH: Right. Then we
16 would recommend a vote on this, and remembering
17 that it's very similar to the one that we just
18 had on the prior measure.

19 MEMBER ANTONELLI: So point of
20 clarification. I heard you say that it was the
21 same consensus document, which would be the
22 source of the evidence. That's different than

1 saying that the information within that document
2 is the same evidence. So could you distinguish
3 that please?

4 MS. CHAVARRIA: Sure. So we look at
5 the recommendations from guidelines and hopefully
6 they're Level A high quality recommendations. In
7 this case, the 2009 Transitions of Care Consensus
8 Policy Statement put out several recommendations,
9 one related to patients should receive a
10 medication, a reconciled medication list. That's
11 Recommendation 1.

12 Recommendation, I don't know what the
13 numbers are, and then another recommendation was
14 that the transition record should include these
15 specified elements. So we took that from the
16 same policy statement, but a different
17 recommendation.

18 MEMBER ANTONELLI: So I guess I want
19 to, for the sake of the record, I want to be
20 really clear. The same source of the evidence
21 may be different and even just the way you just
22 described it qualitatively, I'm willing to give

1 you and your team the benefit of the doubt that
2 it's different evidence, because I guess I'm
3 having trouble wrapping my brain around the fact
4 that the last measure and this measure are based
5 on exactly the same evidence.

6 MS. CHAVARRIA: Yeah, sorry. They're
7 not -- they wouldn't be based on the -- they're
8 based on the exact same policy statement?

9 MEMBER ANTONELLI: Yeah. So it's the
10 source of the evidence. But the question at hand
11 is not the source of the evidence; the question
12 at hand is the evidence itself. So if you could
13 clarify that. Is this -- I don't know whether
14 it's you or it's the reviewer. So if we can get
15 beyond the source of the evidence to what the
16 actual content of the evidence is.

17 MS. CHAVARRIA: Well, the evidence for
18 the consensus policy statement, which was this
19 group that came together and -- they did not
20 have, because it was consensus-based, they did
21 not have the randomized control trials. They did
22 not have the prospective studies. We needed to

1 make a graded evidence, because these are not
2 graded recommendations. These are consensus
3 recommendations.

4 MEMBER ANTONELLI: Okay.

5 MS. CHAVARRIA: So it was based on
6 their discussion.

7 MEMBER ANTONELLI: Okay, okay, and
8 does that square with what the discussants and
9 reviewers with respect to --

10 MEMBER LEATH: Yes.

11 MEMBER ANTONELLI: Yeah? Okay, thank
12 you.

13 MEMBER LEATH: But I did have one
14 other question/comment, and you know, I don't
15 know if it goes in this section or another
16 section, but this measure has multiple components
17 to it. I'm saying this measure has multiple
18 components to it, and I guess clarification for
19 me would be can you address whether any aspects
20 of the systematic reviews that are referenced in
21 this document address that?

22 MS. CHAVARRIA: No.

1 MEMBER LEATH: Okay, thank you.

2 MS. CHAVARRIA: Again, because it was
3 purely consensus and we try not to provide
4 consensus policy statements. But in this case
5 that's what the RX Report Group had to work with
6 unfortunately. So they're not graded as we --
7 and they're not the quality, quantity and
8 consistency of the evidence that we usually
9 provide was not provided here, because of that
10 reason.

11 MEMBER BECKWITH: Well, and to
12 clarify, there's been no new evidence presented.

13 MS. CHAVARRIA: There have been no new
14 guidelines with a systematic review of these are
15 the elements that need to be included, yes.

16 MEMBER KOPLEFF: Just recognizing that
17 one of the elements in this measure is a current
18 medication list, I was just wondering if the
19 consensus-based discussion that stemmed the
20 development of this measure ever addressed or
21 considered -- I guess I'm having trouble
22 reconciling the need for the separate measure we

1 just reviewed specific to a reconciled medication
2 list.

3 And I know we've been through and we
4 don't need to rehash the challenges in defining
5 that. But this is including a medication list.
6 Why not take one fell swoop at a reconciled list,
7 recognizing the evidence is short-handed either
8 way?

9 MS. CHAVARRIA: Unfortunately I --
10 what the thinking of the expert work group was at
11 the time, and to include that one element within
12 this measure and then include it as a stand-
13 alone measure, I'm not quite sure what it was. I
14 can dig around and find that information. But
15 I'm not sure what it was.

16 MEMBER KOPLEFF: Thank you, just
17 curious, helping me sort through this.

18 CO-CHAIR LAMB: John then Ryan.

19 CO-CHAIR CASEY: So in the guideline
20 world, I think part of the challenge is you're
21 using the word consensus. I think the correct
22 word mostly is expert opinion, consensus of

1 expert opinion, which is some form of evidence,
2 right? And that was the basis for both
3 categories. I found this study from Australia,
4 which had a number, 12 articles had met inclusion
5 criteria.

6 Now I didn't check to see if they were
7 all in Australia, but as you go down this, you
8 can see that there were significant gaps in the
9 evidence base, and then I found another one which
10 was admittedly condition-specific, but was in the
11 Annals of Family Medicine from 2015 around heart
12 failure. 41 randomized control trials on
13 transitions of care showing that what they called
14 high intensity transition of care interventions
15 tended to be more effective than moderate or low
16 transition of care interventions.

17 Now I'm not going to get into a debate
18 about which level of care transition this is, or
19 whether what is present in RCTs for heart failure
20 is generalizable. But it is evidence, so and I
21 again think that it makes me worried about going
22 back to 2009 to base this on expert opinion and

1 not taking advantage of more current evidence.

2 So I'd just throw that in, and I
3 didn't go much farther, but someone could
4 probably come up with some additional stuff so --

5 CO-CHAIR LAMB: Ryan.

6 MEMBER COLLIER: I was going to echo
7 what Don just said, which is essentially I think
8 there has been probably quite a bit more
9 published since that consensus statement. I did
10 want to ask a historical question of the
11 Committee. Since this is going up for
12 maintenance, it has passed previous committees,
13 but we're discussing the same evidence base that
14 we discussed then.

15 So I'm just curious, because I feel
16 like maybe we're leaning towards an insufficient
17 evidence vote on this one like we did with the
18 previous one. Historically speaking, is that how
19 things transpired in the past or has our criteria
20 for waiting and voting on the evidence changed as
21 a committee over time or --

22 CO-CHAIR CASEY: I wish Helen were

1 here but let me take a stab. It has changed over
2 time and in fact NQF has paid a lot of attention
3 to making enhancements over a period of about
4 seven or eight years, to really raise the bar. I
5 think the developers could attest that they've
6 done that. Not to be punitive or make things
7 impossible, but to be more constructive about
8 applying evidence.

9 Because let's be frank. Ten years
10 ago, around this subject there wasn't a whole lot
11 of evidence, period and now there is. So I think
12 it fits well with the inclination of the way
13 science is moving around these types of, you
14 know, multi-factorial interventions.

15 MEMBER COLLIER: Thanks.

16 CO-CHAIR LAMB: What we're also saying
17 is along with the evidence growing, the onus on
18 the measure developers for, you know, bringing --
19 being able to bring that back and you've
20 acknowledged that. Not only are there systematic
21 reviews that have been searched here, there are
22 several in the nursing literature as well which

1 I'm very familiar with. In fact, a 2016 review
2 of all transitions of care.

3 So I think where we are is to go back
4 now and review, do another vote on evidence, and
5 the same things go, what we've identified going
6 back to what Alaina was saying was the source ---
7 that Rich clarified, the source is the same, the
8 evidence is different. So we do need to vote on
9 this one separately from our other one. Our last
10 one is same source, different evidence base,
11 okay. Everybody good?

12 All right. So we're going to vote on
13 evidence now, and we're going to go through the
14 same drill in terms of depending on what the
15 outcome of the first level, we may go to a second
16 level.

17 MS. OGUNGBEMI: All right. We are now
18 voting on the evidence for Measure 0647. That
19 measure is called Transition Record With
20 Specified Elements Received by Discharged
21 Patients, and this is specifically discharges
22 from an inpatient facility to home or self care

1 or any site of care. Your options are 1, high;
2 2, moderate; 3, low; and 4, insufficient. Voting
3 is open.

4 [VOTING.]

5 MS. STREETER: Do we also have Barbara
6 Gage available on the phone? If you wanted to
7 vote, Barbara.

8 (Off mic comments.)

9 MS. OGUNGBEMI: Results are 0 votes
10 high and 0 votes moderate, 1 vote low, 15 votes
11 insufficient, 0 percent high, 0 percent moderate,
12 6 percent low and 94 percent insufficient. So
13 Measure 0647 will move on to voting whether the
14 Committee wants to vote for insufficient evidence
15 with exception.

16 (Pause.)

17 MS. OGUNGBEMI: So we are now voting
18 on the insufficient evidence with exception, the
19 potential exception to the empirical evidence for
20 Measure 0647. The options are 1, insufficient
21 evidence with exception; and 2, no exception.

22 [VOTING.]

1 MS. OGUNGBEMI: The results are 15
2 votes insufficient evidence with exception and
3 one vote no exception. 94 percent insufficient
4 evidence and 6 percent no exception, so we will
5 move on to performance gap.

6 (Pause.)

7 MEMBER LEATH: So in terms of -- and
8 from performance gap, I think I alluded to this
9 earlier. There was no data provided on current
10 performance, and that there are -- while there
11 are two studies that are underway, the data will
12 not become available until I believe it's, and
13 please correct me if I'm wrong, later in this
14 year and then next year.

15 MS. CHAVARRIA: They will be reported
16 and when they become -- they will be reported in
17 2017. When they become available to us, I can't
18 tell you. But hopefully, again because they are
19 measures and we're stewarding them and own them,
20 they'll be able to turn that information back to
21 us pretty quickly.

22 MEMBER LEATH: Samira, I don't know if

1 you wanted to add something.

2 MEMBER BECKWITH: I think we've
3 already talked about some of the gaps in the
4 information and in the evidence that the
5 Committee would like to see.

6 MS. CHAVARRIA: Yeah. So I do have --
7 I actually found, and this I can actually provide
8 it to you if you would like, maybe at some point.
9 I'm not sure what the best way for me to provide
10 this would be, because the submission for -- this
11 is a gap, and I actually found a study that
12 determined the extent to which the elements
13 included in this measure were done.

14 So it actually tracked the elements
15 that are recommended within the 2009 Transitions
16 of Care consensus policy. They said let's do a
17 study. Let's figure out whether these are
18 actually being included in the transition record.
19 What the study found was that 97.9 percent of
20 discharge summaries included a diagnosis or
21 reason for admission. So that's good.

22 99.7 percent had procedures and tests

1 performed during the admission, which is another
2 one of the elements that is required for this
3 measure. However, 76.9 percent had the principal
4 diagnosis at discharge. 43.9 percent had the lab
5 results at time of discharge. So that would not
6 then meet this measure. 12.2 had studies pending
7 at discharge, a listing of those studies that the
8 patient would then be able to know hey, I need
9 these results.

10 98.4 had patient instructions. 6.2
11 had a callback number, which is again one of the
12 elements in this measure. So only 6.2 percent of
13 patients would be able to -- would have access to
14 calling about their admission. 41.9 percent had
15 recommendation for follow-up tests and
16 procedures, and 7.7 percent had resuscitation
17 status, and again those are the exact elements
18 included within our measures, and they varied
19 quite a bit on whether they're provided to
20 patients or not, and our expert work group
21 thought that it was important that all of these
22 elements be provided.

1 So at least we provide that
2 performance at this point. We don't have the
3 performance data on this measure as specified,
4 which again we would like to do. But because
5 again these two measures, 647 and 648 have just
6 been taken up by the IPQFR, IPFQR program.

7 MEMBER LEATH: The results that you
8 just spoke about, could you tell me about, you
9 know, whether that was in one facility, multiple
10 facilities? How many participants?

11 MS. CHAVARRIA: Let me see if I
12 brought that with me. I think --

13 CO-CHAIR LAMB: While you do that, I
14 just want to thank everybody. I need to get to
15 the airport, so I'll be in touch. I'm turning
16 things over to Don's very capable hands, and NQF
17 it's good seeing you all.

18 MS. CHAVARRIA: So it was a
19 prospective study done, but only in one hospital.

20 MEMBER LEATH: And the size?

21 MS. CHAVARRIA: And the size, it was
22 377 patients discharged home after

1 hospitalization.

2 CO-CHAIR CASEY: Anything else,

3 Brenda? No. Samira?

4 MEMBER BECKWITH: No.

5 CO-CHAIR CASEY: Any questions from

6 the Committee or on the phone?

7 (No audible response.)

8 CO-CHAIR CASEY: So we were going to

9 proceed with our vote here on the gaps. I think

10 there's some additional information provided by

11 the Committee. It looks like someone from

12 Partners made a comment so we'll proceed.

13 MEMBER BECKWITH: Before we vote, can

14 you just clarify again that if it's insufficient,

15 then this would stop here?

16 MS. MUNTHALI: Yes.

17 MEMBER BECKWITH: Okay.

18 CO-CHAIR CASEY: Insufficient or low

19 combined.

20 MEMBER BECKWITH: Insufficient or low,

21 it would stop here.

22 MS. OGUNGBEMI: We are ready to vote,

1 we are now voting on performance gap for Measure
2 0647. Options are 1, high; 2, moderate; 3, low;
3 and 4, insufficient. Voting is open.

4 [VOTING.]

5 MS. OGUNGBEMI: Lorna, if you could
6 submit your vote please if you are with us still.
7 Okay, we've got it. Thank you. Results are 0
8 votes high, 8 votes moderate, 3 votes low and 4
9 votes insufficient. 0 percent high, 53 percent
10 moderate, 20 percent low and 27 percent
11 insufficient. We've landed in a grey zone, so we
12 are consensus not reached and we will continue.

13 CO-CHAIR CASEY: Let's keep going with
14 our review. Samira. Use your mic Samira.

15 MEMBER BECKWITH: Sorry about that.

16 CO-CHAIR CASEY: It's late in the day.

17 MEMBER BECKWITH: I forgot to turn it
18 on. Okay. We go down to reliability and let's
19 see. As we noted, the patients who are excluded
20 were patients who died and patients who left
21 against medical advice or discontinued care. I
22 think the data elements were very clear in terms

1 of what was included in the transition plan and I
2 don't know that we have much else to add under
3 that.

4 But we didn't have any comments in
5 that area, but it was found to be insufficient in
6 terms of reliability.

7 MS. GRAY: So we provided some
8 additional data for reliability testing for this
9 measure.

10 MEMBER BECKWITH: Okay.

11 MS. GRAY: There's -- we calculated
12 kappas for the different required -- the
13 different required measure components, the
14 numerator reliability was .69; the denominator
15 reliability showed 100 percent agreement. The
16 exception reliability also showed 100 percent
17 agreement, and then overall reliability for the
18 measure was .69.

19 So then that demonstrates that the
20 measure has a substantial level of agreement as
21 far as reliability.

22 DR. TERRY: I just want to mention

1 that was provided by PCPI after our work group
2 call, upon request. So everybody should have
3 gotten copies.

4 MEMBER BECKWITH: Oh, okay. Great,
5 thanks. Somehow I missed it. So I don't have
6 anything else against -- under reliability,
7 unless Brenda you do.

8 MEMBER LEATH: No, I don't have
9 anything else because --

10 (Simultaneous speaking.)

11 CO-CHAIR CASEY: Anyone have any
12 questions or comments?

13 (No audible response.)

14 CO-CHAIR CASEY: Yes Ellen.

15 MEMBER SCHULTZ: So as I brought up
16 with the previous measure, I am really concerned
17 about generalizability of this reliability
18 testing, because it was done just at a single
19 site with a fairly small number of charts. It's
20 not really clear to me how easily the EHR poll
21 guidance could get implemented at multiple
22 locations, and perhaps I think there was a

1 statement within the package that sort of spoke
2 to why there was guidance provided instead of,
3 you know, particular e-measure specifications.

4 That raises some concerns for me. So
5 I don't know if there's anything you want to say
6 in response to that. I'm interested to hear what
7 others on the Committee think. But considering
8 how much has changed around EHRs since the time
9 of this testing, and just how much variation
10 there is in terms of how things are documented
11 within EHRs, I have a hard time really trusting
12 the reliability testing from one site, because
13 this is sort of comparing the EHR poll to like,
14 you know, a gold standard of doing chart review.

15 But really what I'm interested in is
16 like how is the reliability across sites for an
17 EHR poll since that's much more likely to be the
18 way that this is implemented in my understanding.
19 If instead, you know, at least some of the sites
20 that are implementing this now are engaging in
21 chart review, you know, then you want to look at
22 the inter-rater reliability for different chart

1 reviewers.

2 But regardless, I feel like you need
3 to see across places, because this kind of
4 information is likely to be documented in really
5 different ways in different places.

6 CO-CHAIR CASEY: So Ellen, I think
7 you're not quibbling with what the reliability
8 data is that was provided. You're only raising
9 the point that you wonder if -- how that would
10 change in a more electronicized, if that's a
11 word, environment?

12 MEMBER SCHULTZ: Yes, I'm raising
13 concerns about generalizability, and I think that
14 was one of the questions --

15 CO-CHAIR CASEY: From the one site as
16 well, yeah?

17 MEMBER SCHULTZ: From the one, right,
18 yes. So you know, as far as I'm concerned, yes
19 the reliability was good comparing the automated
20 EHR poll process to, you know, a manual chart
21 review. But as I said, this is at just one
22 location and it's not --

1 CO-CHAIR CASEY: So there's really two
2 points, yeah, right.

3 MEMBER SCHULTZ: Yeah, yeah.

4 CO-CHAIR CASEY: Good. Terence,
5 Terry?

6 MEMBER O'MALLEY: Yeah, a follow-up on
7 point two is sort of the generalizability of the
8 process of getting the data. I think that really
9 is critical. I think that goes back to the
10 specifications of the data elements and sort of
11 how tight those are, because having done a
12 project very similar to this for ten years, it
13 took us multiple cycles to get the data elements
14 constrained to the point where we could actually
15 say whether it was present or absent.

16 I just didn't see that sort of level
17 of data, and that concerns me for a national
18 measure. For a within one organization measure,
19 fine, go do it. But it's not -- I can't see it
20 moving beyond just sort of one-offs.

21 Important as it -- and by that I don't
22 mean to dismiss this. I think this is critically

1 important. I think you're on to absolutely the
2 right thing. My concerns are that it's just not
3 specified enough to make it generalizable.

4 CO-CHAIR CASEY: Terry, let me ask you
5 to make a hypothetical guess, again not that we
6 would attribute any finality to it. But given
7 that around, right sort of after this period of
8 the initial reliability testing, I guess this is
9 to Ellen too, there was obviously much more
10 emphasis in the health care system on electronic
11 health records and with the advent of readmission
12 penalties a lot more on care transition.

13 So what would you predict in terms of
14 whether this would be more reliable, the same or
15 less? Do you have any thoughts? I'm just
16 curious about it, because we're obviously not
17 going to get a concrete answer. I'm just worried
18 about, I'm wondering about your impressions.

19 MEMBER O'MALLEY: I think a lot more
20 people are doing it and they're pulling data, so
21 that they -- again, for internal quality
22 improvement use. So but whether what they're

1 pulling is the same from site to site I think is
2 the issue. So my bet is that a lot more people
3 are looking at exactly these data elements.

4 They're looking at them in very different ways.

5 They're all valid for quality
6 improvement, and no one would quibble. They're
7 all getting benefit out of doing it. But my
8 concern is that there's no uniformity across. So
9 my bet is there's less uniformity but more people
10 are doing it.

11 CO-CHAIR CASEY: And CMS developed a
12 CARE tool which I know they intended to make
13 standard, but obviously --

14 MEMBER O'MALLEY: Barbara Page's --

15 CO-CHAIR CASEY: Yes, just in time.
16 But obviously that wasn't adopted as a formal
17 consistent set of data for a lot of reasons.

18 MEMBER O'MALLEY: Yeah. It wasn't --
19 it's a nice data set, so it's a standardized data
20 set and actually all of the data elements are
21 linked back to standardized codes. So you can
22 actually use the CARE Data Set as a library of

1 data elements. I'm not aware of who's actually
2 using it that way, however.

3 MEMBER COLLIER: Right, right. I know.
4 I was just going to piggyback on what Terry and
5 Ellen both said with a concrete example. So I
6 can imagine that within an institution, how they
7 define whether or not cases met the criteria for
8 a plan for follow-up care for example might be --
9 I think there's a start of a definition here, but
10 it's not --

11 There's a lot of room for
12 interpretation, I think, of how to meet that
13 particular definition. And so if you define it a
14 certain way in one institution you might get a
15 certain level of performance and at another
16 institution if they interpret that slightly
17 differently you will see variation, and that
18 starts to get into validity a bit. But that was
19 the concern I had, which is I think related to
20 both of these comments.

21 CO-CHAIR CASEY: Okay. Yes Terry.

22 MEMBER O'MALLEY: If I could give a

1 follow-up, just an example of what we did. So
2 giving a phone number for follow-up test results.
3 In our initial round, everyone gave us a phone
4 number. It turns out some of the phone numbers
5 didn't work, some of the phone numbers were to
6 the main switchboard of the hospital. So the
7 patient would call up. I'm calling for my lab
8 results and they say who do you want to talk to
9 and which lab, which person, which doctor?

10 So we actually had to drill down, so
11 that the criteria became not giving a phone
12 number, but giving a phone number that actually
13 got to the information that individual wanted.
14 We tested samples of that. But it just shows you
15 how you've got to constrain this stuff or you'll
16 get things that --

17 CO-CHAIR CASEY: You must have
18 residents.

19 MEMBER O'MALLEY: We have lots of
20 residents.

21 CO-CHAIR CASEY: Any other thoughts
22 before we vote on this?

1 MS. APURA: I would like to make a
2 comment why this measure is not specified as an
3 e-measure because every facility may have a
4 different template for a care transition record.
5 And then the information required for this
6 measure is based on individualized patient
7 information that is unique to one episode of
8 care.

9 And also given that as you've
10 mentioned, even the variability of the structured
11 data across facilities, it would be challenging
12 to specify it as an e-measure that would cover
13 all possible data elements. So that's why this
14 measure is not --

15 CO-CHAIR CASEY: It's a good point,
16 and it always rubs up against NQF's challenge to
17 endorse measures for accountability, which is I
18 think what we're debating, versus what's the --
19 not that those two are separate, but in the real
20 world, you know, of quality improvement. So the
21 point is well taken. So Ellen.

22 MEMBER SCHULTZ: Well, I would just

1 respond. All those reasons you just pointed out
2 are exactly why I feel like I need to see
3 reliability testing at multiple sites.

4 MS. GRAY: Yeah. I think this -- the
5 testing and the development of the measures
6 predates pretty much all of us. But the testing
7 project, you're right. It's a small sample size
8 to be frank.

9 The testing project was -- for
10 reliability was conducted at a health practice
11 that was a Tier 3 medical home and it's -- it was
12 just the one site that deals with seven to eight
13 thousand discharges per year. Even though it's a
14 large facility, I'm not really sure why they only
15 decided to pull a sample of 100 patients, I'm
16 sorry of 100 discharges in order to look at the
17 measure. And I know that, you know, we generally
18 provide -- we generally perform reliability
19 testing with larger data sets that include lots
20 of facilities like or physicians like the PQRS
21 data set, things like that.

22 So in -- this is something that we

1 would obviously take back as a recommendation to
2 perform an updated testing project that would
3 include multiple sites, and so that we could
4 demonstrate, you know, better and you could feel
5 better about, you know, supporting the measure,
6 knowing how it would perform on a national scale
7 versus just that one facility. So it's a really
8 good point.

9 MEMBER SCHULTZ: Yeah.

10 CO-CHAIR CASEY: Ryan? I'm sorry
11 Ryan. Go ahead Ellen.

12 MEMBER SCHULTZ: I was going to say
13 for my money, more sites is more important than
14 the sample size at each site. It's the number of
15 sites is the N that I --

16 CO-CHAIR CASEY: So let me mark time.
17 Who has to leave by four?

18 (No audible response.)

19 CO-CHAIR CASEY: All right, good. And
20 let me ask our colleagues from PCPI, do you
21 expect that a lot of what we're debating here is
22 going to trickle into the next two measures as

1 well? Okay, good. So just keep that in mind,
2 knowing that there will be differences so we can
3 move ahead and get our work done, okay. Not that
4 I'm rushing you, but we're going to go to the
5 vote.

6 MS. OGUNGBEMI: Yes. We are now
7 voting on the reliability for Measure 0647. The
8 options are 1, high; 2, moderate; 3, low; and 4,
9 insufficient. Voting is open.

10 [VOTING.]

11 MS. OGUNGBEMI: Results are 0 votes
12 high, 4 votes moderate, 6 votes low and 5 votes
13 insufficient. 0 percent high, 27 percent
14 moderate, 40 percent low and 33 percent
15 insufficient. Measure 0647 fails reliability.

16 CO-CHAIR CASEY: And then this is a
17 must pass, correct? So we are back to where we
18 were. Let's continue on with just finishing,
19 you know, as quick and dirty as you can the
20 review of the rest of this report, and then we
21 will take a 6.5 minute bio break, okay.

22 MEMBER HOHL: Don, this is Dawn. I am

1 on the next measure, and I do need to get in the
2 car and start driving at 3:30. I think I could
3 probably remember a lot, but I would not have
4 all my notes in front of me. Just so that you
5 know.

6 CO-CHAIR CASEY: Thanks Dawn, and
7 Karen is here to help. So Karen, we'll ask you
8 to step up if you don't mind and Dawn you can
9 fill in. But I think the good news is probably a
10 lot of the discussion is going to be echoed with
11 what we've got. So she's good.

12 MEMBER HOHL: Right, right, okay.

13 CO-CHAIR CASEY: Thank you.

14 MEMBER HOHL: Okay. We had broken it
15 up, so I think we had a little bit of a system.
16 So I appreciate that, thank you.

17 CO-CHAIR CASEY: Great, and you'll
18 continue to vote too, right?

19 MEMBER HOHL: Well, can I email
20 someone to vote?

21 CO-CHAIR CASEY: You can email or you
22 can whisper it on the phone. We won't listen.

1 MEMBER HOHL: Okay, okay, okay.

2 CO-CHAIR CASEY: Thanks.

3 MEMBER BECKWITH: Yeah, okay. So the
4 validity testing is next, and I would say it's
5 the same issues that come up under validity
6 testing, in the fact that it was one site and
7 some of the same discussion that we just had
8 about reliability. So let me just ask if people
9 have comments or Brenda, if there's something you
10 want to add or our developers want to add.

11 MEMBER LEATH: No. I would echo what
12 you just said, just indicating that the method
13 for validity was based on face validity and I
14 don't know that I have any other additions.

15 CO-CHAIR CASEY: You think we've
16 captured most of the spirit of this in the --
17 okay.

18 MEMBER BECKWITH: Under reliability.

19 CO-CHAIR CASEY: Any other comments on
20 the reliability? You want to keep going?

21 MEMBER BECKWITH: Uh-huh, okay. And
22 we don't have to vote after --

1 CO-CHAIR CASEY: Nope.

2 MEMBER BECKWITH: Okay, so then we go
3 to threats to validity, and I think -- so that
4 discussion we've already had also, in terms of
5 needing to have studies over different sites,
6 maybe additional numbers in those sites. I think
7 we've had that conversation, but I would ask if
8 anybody has anything to add.

9 CO-CHAIR CASEY: Anything Barbara?
10 You good? Anyone on the phone?

11 (No audible response.)

12 CO-CHAIR CASEY: So --

13 MEMBER BECKWITH: Okay. So as to the
14 --

15 CO-CHAIR CASEY: Feasibility.

16 MEMBER BECKWITH: Oh feasibility.

17 Well, in terms of being repetitive, for
18 feasibility I think we've also had that
19 discussion and would ask if anybody has anything
20 to add.

21 CO-CHAIR CASEY: Well, I would just
22 speculate that my hypothetical question to Dr.

1 O'Malley would posit the question of, you know,
2 whether with the increased intensity of activity
3 around this particular issue by virtue of many
4 factors in the environment, that we would hope
5 this would become more feasible in the present
6 day and future.

7 MEMBER BECKWITH: I think that was a
8 very good --

9 CO-CHAIR CASEY: That's a decent
10 assumption, although it's speculative.

11 MEMBER BECKWITH: I think and am very
12 hopeful that that would be happening, and I think
13 that we would hopefully see some difference with
14 some more testing across sites.

15 CO-CHAIR CASEY: Thank you. Good. So
16 anything else on the list here? Are we good?

17 MEMBER BECKWITH: Feasibility and use.

18 CO-CHAIR CASEY: Use, usability.

19 MEMBER BECKWITH: Yes.

20 CO-CHAIR CASEY: Use and usability.

21 MEMBER BECKWITH: Right, thank you.

22 Usability and use.

1 CO-CHAIR CASEY: I guess it depends on
2 all the other factors, would you say?

3 MEMBER BECKWITH: Yes, I would.

4 CO-CHAIR CASEY: Good.

5 MEMBER BECKWITH: Any other comments?

6 CO-CHAIR CASEY: Any other comments?

7 MEMBER LEATH: I just have one.

8 CO-CHAIR CASEY: Yes Brenda.

9 MEMBER LEATH: You know, I think that
10 there is potential with this measure, and I
11 think, you know, I don't want to beat a dead
12 horse, but probably with further definition and
13 specificity and, you know, having a larger test
14 would yield something, a totally different
15 picture.

16 So I just want to impart those words
17 to you, because I do see the relevance of the
18 measure.

19 CO-CHAIR CASEY: And I think you're
20 saying this is such a high stakes issue that we
21 really are attempting to make this work well
22 because the stakes are even more higher than

1 they've ever been, and that this is -- it's
2 important for us to get it right, and that's why
3 this committee is spending so much duty and care
4 to really analyze this so --

5 MEMBER LEATH: Thank you for saying
6 that so eloquently because yes, care coordination
7 doesn't get its just due, and I mean that's a
8 very critical element. So yes, thanks.

9 CO-CHAIR CASEY: Good, okay. 6.5
10 minutes for our break, and then we'll be back,
11 okay.

12 (Whereupon, the above-entitled matter
13 went off the record at 3:20 p.m. and resumed at
14 3:27 p.m.)

15 CO-CHAIR CASEY: Our PCPI colleagues
16 have a flight to catch pretty soon, so it's in
17 their best interest and ours to maybe even finish
18 a little early. So let's work really hard to try
19 to get through this, knowing that there's a lot
20 of discussion. Karen is going to lead off. I
21 called myself, because I'm a little hoarse, the
22 godfather and she's the godmother. So Karen, do

1 you want to take us home?

2 MEMBER MICHAEL: Great, thank you. So
3 the next one 0648 looks at that same discharge
4 document you're talking about, and its intent is
5 to measure the timeliness of the delivery of that
6 document to the next care step, primary care
7 physician, facility or other health care
8 institution that's going to do follow-up care. I
9 don't know if we need to have the developers with
10 their comments to start?

11 CO-CHAIR CASEY: Is Amy here? Can
12 someone work the screen for us?

13 MEMBER MICHAEL: So in terms of -- did
14 you want to make introductory remarks?

15 MS. CHAVARRIA: Thank you, yes. So
16 this measure assesses the percentage of
17 discharges from an inpatient facility for which
18 the transmission record was transmitted within 24
19 hours of discharge. Now someone did mention, and
20 I wanted to make sure that I address it. Someone
21 did mention in the standing committee comments
22 that this measure should be a companion to the

1 other measures perhaps, and the PCPI expert work
2 group developed Measures 646, 647 and 648 as a
3 bundle.

4 However, we do find that implementers
5 may split the measures as needed for their
6 particular programs, but that was what the expert
7 work group would have preferred for these
8 measures to actually be taken together.

9 Again, the rationales for
10 communication and information exchange should
11 occur in an amount of time that will allow the
12 receiving provider to effectively treat the
13 patient based on condition or diagnosis. That's
14 the crux of this measure and that is the intent,
15 and it is based once again on the 2009
16 Transitions of Care Consensus Policy Statement.

17 MEMBER MICHAEL: Which takes us right
18 to evidence, thank you very much. So the same
19 discussion we had with 647, the same consensus
20 document was used here. So if you remember, we
21 went to a vote last time on this, and the
22 ultimate vote was insufficient with exception.

1 So we have the same evidentiary basis for this
2 one, and unless there are other comments, we
3 probably can proceed to the vote.

4 CO-CHAIR CASEY: Anyone object to
5 that? Dawn, yeah I'm sorry. Chris, and Dawn,
6 are you on the phone?

7 MEMBER HOHL: Yes, I'm here.

8 CO-CHAIR CASEY: Are you in your car
9 yet or not?

10 MEMBER HOHL: Yes, I'm in the car.

11 CO-CHAIR CASEY: Okay. So if you're
12 driving, just whisper.

13 MEMBER HOHL: Well I don't even need
14 to whisper. I would vote insufficient with
15 exception.

16 CO-CHAIR CASEY: Thank you. Well,
17 we're going to vote first on the first process,
18 and then we'll vote second. So we vote --

19 MEMBER HOHL: Oh, I'm sorry. I jumped
20 ahead, I'm sorry.

21 CO-CHAIR CASEY: So you're going to
22 vote for, okay.

1 So Yetunde.

2 MS. OGUNGBEMI: Yes. We are now
3 voting on Measure 0648, Timely Transition Record
4 With Specified Elements Received by Discharge
5 Patients, and this is also discharges from an
6 inpatient facility to any other site of care.
7 Your options are 1, high; 2, moderate; 3, low;
8 and 4, insufficient. Voting is open.

9 [VOTING.]

10 MS. OGUNGBEMI: Results are 0 high, 0
11 moderate, 1 low and 14 insufficient. 0 percent
12 high, 0 percent moderate, 7 percent low and 93
13 percent insufficient. So we will now vote on
14 whether the Committee wants to do a vote for
15 insufficient evidence with exception.

16 CO-CHAIR CASEY: Deja vu all over
17 again. Let's go.

18 MS. OGUNGBEMI: We are now voting on
19 Measure 0648, evidence on -- the empirical
20 evidence with an exception. Your options are 1,
21 insufficient evidence with exception; and 2, no
22 exception.

1 CO-CHAIR CASEY: And we have Dawn's
2 vote too.

3 [VOTING.]

4 CO-CHAIR CASEY: We have it? Are we
5 good?

6 MS. OGUNGBEMI: We need to revote
7 because -- we need to revote. Just give me one
8 second.

9 MEMBER MICHAEL: We have more votes
10 than people. We're in Washington, D.C.

11 (Laughter.)

12 MS. OGUNGBEMI: That's okay.

13 (Pause.)

14 CO-CHAIR CASEY: Ready, and we already
15 have Dawn's vote so --

16 MS. OGUNGBEMI: Voting is open.

17 [VOTING.]

18 MS. OGUNGBEMI: Yeah, we're missing
19 one vote. Oh, got it. Results are 13 votes
20 insufficient evidence with exception and 2 votes
21 no exception. 87 percent insufficient evidence
22 with exception, 13 percent no exception. So we

1 will go to performance gap.

2 CO-CHAIR CASEY: Karen.

3 MEMBER MICHAEL: Okay. So with
4 respect to performance gaps, as we said with the
5 prior measure, there is no data on this current
6 measure. There is a lot of data out there on the
7 impact of untimely discharge communication, and
8 the negative effects that has on care. There's a
9 more recent article even than the one that you
10 guys have from 2016 Journal of Hospital Medicine,
11 that concluded the same thing.

12 Longer days that can lead discharge
13 summaries were associated with higher rates of an
14 all-cause readmission. Timely discharge summary
15 completion time may be a quality indicator to
16 evaluate current practice, and a potential
17 strategy to improve patient outcomes.

18 So while there's no data for this
19 specific measure, there's definitely data out
20 there that shows there's performance gaps in this
21 area.

22 CO-CHAIR CASEY: Dawn, do you have

1 anything you want to add on gaps?

2 MEMBER HOHL: No Terry, not at all.

3 Thank you.

4 CO-CHAIR CASEY: Any questions on
5 this? Yes, Samira.

6 MEMBER BECKWITH: I just wanted to
7 comment that when the commenter comments notes
8 about the skilled nursing facility, and just when
9 this is being reviewed or being presented in the
10 future, I think that really has some merit. The
11 SNF, the other locations that someone might be
12 transferred to, that 24 hours is not going to be
13 helpful and they might turn around and end up
14 back in the emergency room or back in the
15 hospital. So, I just wanted to point that out.

16 MEMBER MICHAEL: Yeah, I would agree
17 that 24 hours is a long time. But I think again
18 it's a place to start.

19 CO-CHAIR CASEY: It's a floor.
20 Terence.

21 MEMBER O'MALLEY: Just to make a
22 comment for the at discharge criteria, because 24

1 hours is a lot better than what it used to be,
2 which in our hospitals was 30 days by law --

3 MEMBER MICHAEL: Right, until it was
4 dictated and signed off.

5 MEMBER O'MALLEY: Then you had another
6 30 and then another 15 before anything happened.

7 MEMBER MICHAEL: I'm old enough to
8 remember that.

9 MEMBER O'MALLEY: It's a huge
10 improvement to get it to 24 hours, but the
11 reality is that readmissions occur in that first
12 24 hour gap, and so if you don't have the data
13 when the person shows up in the ED, that's a
14 major quality issue.

15 And then specifically the SNF issue,
16 that the discharge paperwork is actually the new
17 orders, so that you cannot really begin care
18 without them, and that's important. So just I
19 think at time of discharge is a reasonable
20 approach.

21 CO-CHAIR CASEY: Good points. So,
22 ready to vote on this performance gap? Ready?

1 MS. OGUNGBEMI: We are now voting on
2 performance gap for Measure 0648. Your options
3 are 1 high, 2 moderate, 3 low and 4 insufficient.
4 Voting is open.

5 CO-CHAIR CASEY: And Dawn, we're
6 holding our ears for your vote so --

7 MEMBER HOHL: Insufficient.

8 (Voting.)

9 MS. OGUNGBEMI: Results are 0 votes
10 high, 7 votes moderate, 1 vote low and 7 votes
11 insufficient. Zero percent high, 47 percent
12 moderate, 7 percent low and 47 percent
13 insufficient. We are -- we've reached -- we have
14 not reached consensus. We landed in a gray zone,
15 so we will continue on to reliability.

16 MEMBER MICHAEL: Okay. With respect
17 to reliability, the data provided mirrors the
18 data provided for 647. There was updated
19 reliability information provided showing the
20 numerator and denominator reliability of 100
21 percent. However, the same issues we talked
22 about last time -- a smaller sample size and

1 testing -- are still present.

2 MEMBER HOHL: And Karen, the only thing
3 I would add to that, there was an exclusion in
4 the data that was not clear to me, that there was
5 an exclusion of cancer patients who died. I'm
6 not sure why all patients who died would not have
7 been excluded.

8 MEMBER MICHAEL: Yeah, thank you Dawn.
9 I thought on the call we had clarified that that
10 was actually a typo.

11 MEMBER HOHL: Did we? Okay. We --

12 MEMBER MICHAEL: Yeah, the exclusion --

13 MEMBER HOHL: -- may have, maybe I
14 missed it.

15 MEMBER MICHAEL: Well, for the record
16 that's good to point out. For the record, the
17 exclusion should be all patients who died and
18 patients who left against medical advice.

19 CO-CHAIR CASEY: And I think that the
20 generic feeling here is that not only does the
21 measure of timely transmission have to be
22 reliable, but the reliability of the content is

1 important too, right? So these two -- even
2 though they're --

3 MEMBER MICHAEL: Well I mean that's a
4 little -- that's a little nebulous in the way the
5 specs are written, because they're looking for
6 the transmission here. But we're not really
7 measuring the elements as part of the --

8 CO-CHAIR CASEY: I understand.

9 MEMBER MICHAEL: Which is why I think
10 the developers saw a bundled approach to the
11 measures, which does make sense.

12 CO-CHAIR CASEY: Yeah.

13 MEMBER HOHL: But I think that might
14 speak also to -- I looked in the literature
15 review. When you do a discharge summary, it's
16 seven days, one day, 30 days after the patient's
17 discharge, you then have to start questioning the
18 accuracy of it, if it's not done at that time of
19 discharge.

20 So I would actually advocate if
21 there's any possibility to look at it as a best
22 practice, that it be at the time of discharge,

1 again because of the accuracy. It would be more
2 likely than any time thereafter.

3 CO-CHAIR CASEY: Terry.

4 MEMBER O'MALLEY: Not to belabor the
5 point, but having the specs -- really tight specs
6 on what you want the content to be. So here's
7 the discharge packet and then it's got to meet
8 the standard of a good discharge packet. I think
9 that's really critical for this measure, because
10 if you're just sending garbage that -- even if
11 you do it in a timely fashion, it doesn't get you
12 anywhere.

13 CO-CHAIR CASEY: Rich.

14 MEMBER ANTONELLI: So I'm going to
15 poke you a little bit on that one, because -- and
16 I don't know whether PCPI team feels the tension
17 here with these being considered as a non-bundle,
18 as I would argue that the first measure gets at
19 the content. The second one is the timing, and
20 so I think in the context of unbundling the
21 bundle, this measure is only about timeliness.

22 I don't know whether I'm going to be

1 out of order or not but I'll frame this. Is it
2 okay that we proceed with these in unbundled
3 fashion? Is that acceptable to you? And is it
4 fair to me to ask them, because I don't want to
5 overstep the chair's responsibility here.

6 MEMBER ANTONELLI: It's okay for you
7 --

8 (Off microphone comments.)

9 MEMBER ANTONELLI: Yeah, okay, all
10 right, thank you, because obviously I totally
11 agree with him. But in the context of this
12 measure, I have to disagree with him. Okay.

13 CO-CHAIR CASEY: Okay. Good thing the
14 Bostonians are over there. The Committee ready
15 to vote? Let's go.

16 MS. OGUNGBEMI: We are now voting on
17 reliability for Measure 0648. Your options are 1
18 high, 2 moderate, 3 low and 4 insufficient.
19 Voting is open.

20 MEMBER HOHL: This is Dawn. I vote
21 insufficient.

22 (Voting.)

1 CO-CHAIR CASEY: We got them.

2 MS. OGUNGBEMI: Results are 0 votes
3 high, 4 votes moderate, 4 votes low and 7 votes
4 insufficient. Zero percent high, 27 percent
5 moderate, 27 percent low and 47 percent
6 insufficient. So Measure 0648 fails reliability.

7 CO-CHAIR CASEY: So we're again really
8 following the pathway of the other two measures.
9 Karen, do you want -- do you want to add anything
10 else to your elegant review?

11 MEMBER MICHAEL: If we need to go
12 through the rest, we can. But I think it's going
13 to pretty much mirror what we saw for the
14 previous measure.

15 CO-CHAIR CASEY: Just at a high level,
16 just --

17 MEMBER MICHAEL: Sure. So for
18 validity testing, there was updated information
19 submitted on the face to face -- face validity,
20 again smaller numbers. But they did show
21 moderate strength of agreement.

22 On feasibility, these are elements

1 that can be extracted from the record. And
2 ideally you'd find them in an EMR, but if not you
3 can abstract them from the record. So it does
4 have a moderate -- or a preliminary rating of
5 moderate for feasibility, which I agree with.

6 CO-CHAIR CASEY: I think I saw --
7 maybe it rolled by -- a kappa of .49.

8 MEMBER MICHAEL: I'm sorry?

9 CO-CHAIR CASEY: I think I saw the
10 kappa was .49 in this measure.

11 MEMBER MICHAEL: Yeah, .49 for
12 validity, right.

13 CO-CHAIR CASEY: For validity, right.

14 MEMBER MICHAEL: Which is moderate.
15 So feasibility is moderate, and then for
16 usability and use -- again this is one of the
17 measures that was picked up by the Inpatient
18 Psychiatric Facility Quality Reporting Program.
19 So results for the measure themselves should be
20 coming available later this year and hopefully
21 would be available when the measure comes back.
22 But in my opinion, it's definitely something we

1 should be measuring and taking action on.

2 CO-CHAIR CASEY: Thank you. Any other
3 comments? Dawn, you good?

4 MEMBER HOHL: Yes. I 100 percent
5 agree.

6 CO-CHAIR CASEY: All right. Let's get
7 out of here. Let's have Charissa and Terry bring
8 us home. Do I have that right? I'm sorry. So
9 we're on the final one point, 0649.

10 MS. CHAVARRIA: Thank you. So this
11 measure is Transition Record With Specified
12 Elements Received by the Discharged Patient, and
13 this is from the emergency department discharges,
14 as opposed to the other one, which was from
15 inpatient discharges. The rationale for this
16 measure is that it was developed to help ensure
17 that patients receive the information to care for
18 themselves at home, and be able to follow up as
19 needed to manage their injury or condition after
20 an emergency department visit.

21 Again, our expert work group thought
22 this was an important thing to measure, and it is

1 based once again on the 2009 Transitions of Care
2 Consensus Policy Statement. I have some -- we do
3 not have performance data on the measure as
4 specified, as this measure unfortunately has not
5 been picked up for implementation that we know
6 of.

7 So all the other ones we're waiting
8 for data. For this one, we're not exactly sure
9 whether it has been implemented and whether data
10 will be available. We have not identified any
11 programs that do that.

12 MEMBER PACELLA: All right. So as
13 summarized by the measure developer, this is --
14 the data presented in support of this measure was
15 similar to the other measures and was based on
16 expert consensus. No new evidence or data has
17 been presented.

18 We are not aware of any other new data
19 that exists that wasn't presented in this arena,
20 although I would note separately that the 2017
21 lens tells us that things are quite different in
22 this realm probably than they were ten years ago,

1 because the ED transition record was part of one
2 of the meaningful use things that many places
3 anticipated was going to be implemented, even
4 though it wasn't.

5 So I think without current data, it
6 would be very hard to even say that expert
7 consensus today would be the same. So in that
8 lens it, you know, seems like a good idea to send
9 people home with the information on the list, but
10 I guess we're on the practice of evaluating
11 evidence.

12 There were not other questions that
13 were raised on the call related to this, and so I
14 think without any other additional or new
15 information, we could go ahead and vote on the
16 evidence previously presented. And again,
17 recognizing that the previously submitted
18 comments from the prior Committee evaluation
19 included the fact that there are no ED discharges
20 looked at in any of these measures.

21 So none of the data applies to
22 discharges from the ED, either reliability or

1 this one.

2 CO-CHAIR CASEY: Terry, do you have
3 anything to add?

4 MEMBER O'MALLEY: No.

5 MEMBER PACELLA: We just -- we talked
6 in advance.

7 CO-CHAIR CASEY: I did have a study
8 from the VA QUERI, Q-U-E-R-I, which is their
9 Quality Improvement Research Group from January
10 2015, who did an elegant systematic review that I
11 didn't mention before about transitional care and
12 mentioned explicitly in that review that very
13 little had been done in other settings outside of
14 the hospital, which I think probably still
15 includes the ED.

16 But for the most part, the bulk of the
17 evidence is on the hospital side. So we have
18 work to do. So let's -- if there's no further
19 comment, let's vote.

20 MS. OGUNGBEMI: We are now voting for
21 Measure 0649, evidence. Your options are 1 high,
22 2 moderate, 3 low and 4 insufficient. The title

1 of this measure is called Transition Record With
2 Specified Elements Received by Discharge
3 Patients, and this is from emergency department
4 discharges to ambulatory care or home health
5 care.

6 (Voting.)

7 MEMBER HOHL: This is Dawn. I vote 4.

8 MS. OGUNGBEMI: Results are 0 votes
9 high, 2 votes moderate, 1 vote low and 12 votes
10 insufficient. Zero percent high, 13 percent
11 moderate, 7 percent low and 80 percent
12 insufficient. Measure 0649 passes on evidence.
13 And does the Committee want to go to insufficient
14 evidence with exception?

15 MEMBER PACELLA: Go.

16 MS. OGUNGBEMI: We are now voting on
17 insufficient evidence with exception for Measure
18 0649. Your options are 1, insufficient evidence
19 with exception, 2 no exception.

20 (Voting.)

21 MEMBER HOHL: This is Dawn. I vote 1.

22 MS. OGUNGBEMI: Results are 11 votes

1 insufficient evidence with exception, 4 votes no
2 exception. Seventy-three percent insufficient
3 evidence with exception, 27 percent no exception.
4 We can move to performance gap.

5 CO-CHAIR CASEY: Charissa.

6 MEMBER PACELLA: Okay. So summarizing
7 the data on performance gap, there really was not
8 any data related to performance gap presented
9 related to this measure that has looked at any
10 emergency department discharge. So there is
11 virtually non-existent data in this realm, so we
12 can all make our best guess as to whether a gap
13 exists. Sorry.

14 MS. CHAVARRIA: We had a tough time
15 with this one. There's very limited data or
16 hardly any. But we were able to find a 2011
17 study that found that 76 percent of patients
18 received an explanation of their symptoms, and 30
19 percent of patients received instructions about
20 symptoms that should cause them to return to the
21 ED.

22 Additionally, in terms of examining

1 written ED discharge instructions, but this was
2 specific to different types of patients. So for
3 hypoglycemic patients, we would hope for broader.
4 But it revealed that many were missing key
5 components of home management and patient safety.

6 For example, only 21 percent were
7 advised -- patients were advised to frequently
8 monitor their blood glucose, and then another
9 study of discharge instructions for patients
10 prescribed acetaminophen containing narcotics
11 found that no patients were instructed to avoid
12 the use of other acetaminophen-containing
13 medications. So these were smaller studies but
14 we were able to find them.

15 MEMBER PACELLA: Yeah, and so I think
16 there's -- you know, my impression is that
17 there's a lot of things that address small pieces
18 of this.

19 MS. CHAVARRIA: Yeah.

20 MEMBER PACELLA: The real problem that
21 I think we run into here is that it would be
22 really helpful to actually have a sample of cases

1 that look at today, because even five years ago
2 in this realm is not today. And so I think that
3 what might pass that muster several years ago in
4 anticipation that more data is coming, when no
5 more data is collected and no more evaluation is
6 done it becomes a little stale to say okay, well
7 we'll just keep waiting until somebody implements
8 it or gets the data. So that's my -- that's my
9 kind of worry about that.

10 CO-CHAIR CASEY: Charissa, is there a
11 My ED transmission record app yet that's secure?

12 MEMBER PACELLA: I would really like
13 to have a fully shared record with the patients
14 and have them own their record, but that's my
15 future state.

16 CO-CHAIR CASEY: Okay, sorry.

17 MEMBER PACELLA: All right, no, quite
18 all right. There is a myUPMC, so -- I'm not
19 advertising that. Okay. So are there other
20 comments related to performance gap from anyone
21 else? I mean if there aren't, we should --

22 CO-CHAIR CASEY: Shall we?

1 MEMBER PACELLA: -- vote on
2 performance gap.

3 CO-CHAIR CASEY: All right. We know
4 how to do this.

5 MS. OGUNGBEMI: We are now voting on
6 performance gap for Measure 0649. The options
7 are 1 high, 2 moderate, 3 low and 4 insufficient.
8 Voting is open.

9 MEMBER HOHL: This is Dawn. I vote 4.
10 (Voting.)

11 CO-CHAIR CASEY: I always get nervous
12 when we're talking about EDs and the sirens are
13 going off in the background.

14 MS. OGUNGBEMI: Results are zero votes
15 high, 2 votes moderate, 1 vote low and 12 votes
16 insufficient. Zero percent high, 13 percent
17 moderate, 7 percent low and 80 percent
18 insufficient. Measure 0649 fails on performance
19 gap.

20 CO-CHAIR CASEY: And that's a must
21 pass, right? So we are -- we're stopping here,
22 although if you could just fill in any remaining

1 blanks for us specific to this measure, you and
2 Terry, we'd appreciate it.

3 MEMBER PACELLA: Sure, and so it's a
4 failure primarily due to lack of evidence rather
5 than -- or lack of data rather than any other
6 specific criterion. Under validity testing, same
7 issue. It was the same data presented for the
8 prior studies, so I would just echo the same
9 comment, that certainly for an emergency
10 department-based metric it would need to be
11 emergency department discharges probably that
12 were looked at, because we're presuming processes
13 are the same and I can guarantee they are not in
14 most places.

15 And then on the other side, you know,
16 more than one site would be helpful. Those
17 comments were made. Under threats to validity,
18 there was the added concern that if there's going
19 to be face validity testing for a measure like
20 this, it should probably include some people with
21 knowledge of emergency department care or
22 processes.

1 So looking down the list of people
2 from the validity testing, it didn't look like
3 there was anybody there who would have
4 necessarily expertise in the area of emergency
5 care, although two of the original 38 developers
6 or whatever did.

7 And then those -- so that comment was
8 made. It seemed like feasibility was good
9 potential, especially with EHR advances recently,
10 and likewise usability. I wonder if the fact
11 that it's not in use is more a reflection of
12 people's perceived value, that this is already
13 sort of mostly being done and that filling in
14 whatever gaps exist may not be of very high
15 perceived value.

16 MEMBER O'MALLEY: And if I could just
17 add two comments, I guess. One is, again, the
18 choice of what to include in this discharge
19 packet. I just respectfully submit that asking
20 individuals who are users of the ED what they
21 would value most leaving the ED might be a good
22 place to start, because that might get you more

1 towards full validity.

2 And then the second -- and this is
3 probably not fair because it's going back to the
4 other med rec, medication piece. It's just again
5 around specifics, about how you define your data
6 elements and -- maybe I'll follow up on that one
7 if we have time to go back on medication-
8 specific, because it doesn't really apply to the
9 ED. So, withdraw that comment.

10 CO-CHAIR CASEY: Well, so it's okay.
11 I mean you're not on the record. But the word
12 packet makes me very nervous because the packet I
13 usually get is one page of useful information and
14 ten pages of, you know, why did I hate my mother
15 when I was in 6th grade and, you know, blah blah
16 blah. I actually loved my mother when I was in
17 6th grade, but you know what I mean. There's all
18 this stuff there that is like just print it out,
19 right.

20 MEMBER O'MALLEY: So you obviously
21 don't work at Partners, where you get a 40-page
22 discharge packet.

1 (Laughter.)

2 CO-CHAIR CASEY: Thank you. So, any
3 other comments for this? So let's mark time.
4 It's four o'clock. I want to let -- Rich, go
5 ahead.

6 MEMBER ANTONELLI: Just in terms of
7 enhancing the value, I think this would be a
8 great measure if it was receipt by somebody, so
9 transmitting at the time of ED discharge. But
10 I'd love to be able to look at this as a
11 performance measure, you know, and then you can -
12 - it could be the medical home, it could be the
13 subspecialist, it could be the SNF, wherever the
14 patient is going. But I'd love to see a measure
15 that really pushes that integrated care
16 opportunity.

17 CO-CHAIR CASEY: Yes, Charissa.

18 MEMBER PACELLA: As much as we all,
19 you know, love and don't love the CAHPS projects,
20 I have to say it is one of the things that I
21 think is actually probably more beneficial than
22 something like this has been, that they're asked

1 the question did you get information about your
2 medications, did you understand it, which I think
3 is a much more patient-centered approach than did
4 we push the 12 pages of information out to you.

5 CO-CHAIR CASEY: And are you on the
6 right medication and are you getting better and,
7 you know, how are you feeling and -- right? So -
8 - sorry. So, I know our friends from PCPI have
9 to Uber their way to Reagan. Let me before they
10 go say first of all thank you. I know that in
11 some regards you're disappointed.

12 But I also want to highlight the fact
13 that PCPI has done their best and is not a multi-
14 million dollar organization that just develops
15 measures. They've done this for a long time and
16 I think this is, to my second point, an
17 opportunity for us to codify -- maybe with
18 staff's help -- some of the things that came out
19 of this because quite frankly this fits directly
20 into our gaps discussion.

21 I think that we were talking up here,
22 but this may, if you don't mind, give us some

1 grist for the mill, both from the standpoint of
2 the challenges of performance measurement, but
3 also highlighting the importance of appropriate
4 funding levels to develop these measures in a way
5 that is timely, that reflects current care, that
6 is forward-looking in terms of the use of new
7 technologies, yadda, yadda, yadda.

8 Because this isn't really, in my
9 opinion, their fault. So we just want to thank
10 you so much for being here and we appreciate it,
11 and we hope that we can be collaborative with you
12 about this, you know. As much as I know you're
13 disappointed about the outcome for now, we are on
14 your side. So we want to -- I want to say that
15 on behalf of the Committee. So we thank you.

16 MS. CHAVARRIA: Thank you, and I will
17 hold my tears for when I'm outside.

18 (Laughter.)

19 CO-CHAIR CASEY: Okay.

20 MS. CHAVARRIA: No, no, but thank you.
21 It's been -- thank you for your time. The
22 feedback -- again, very thoughtful feedback, very

1 useful feedback that we will certainly take back
2 with us.

3 CO-CHAIR CASEY: My problem is they
4 all live in Chicago and they know where I live
5 so, you know, it's like -- they're coming to get
6 me.

7 (Laughter.)

8 CO-CHAIR CASEY: So, thank you. You
9 can stay as long as you like, but I understand
10 this. Let me ask at this point, because we did
11 get started -- and I think we made good progress
12 on the gaps discussion, and I know Gerri was very
13 intentional with me last night in being sure we
14 had enough time here.

15 Let me take a pause and ask Peg if
16 we're tired, whether we could sort of take a
17 break. I don't mean in five minutes. I mean for
18 a few days and maybe have an opportunity once
19 we've brought some of this stuff that's written
20 down back together to have another discussion
21 about it, knowing that you'll do your homework
22 too on the preferred practices as well if you

1 haven't, right?

2 MS. NACION: So we do have a post-
3 comment call. I know we'll have that and we will
4 -- we can continue it on that call. We'll also
5 do relating and competing. We'll have to look at
6 the measures, because some of the measures that
7 are in that list are maybe not going to be
8 measures endorsed anyway, so we'll have to see
9 how that goes.

10 But I think we can if people feel
11 they're ready to leave. We have a few
12 housekeeping things. We have to open it for
13 public comment, and we have to do next steps.

14 CO-CHAIR CASEY: Yes.

15 MS. NACION: But if people want to --
16 I don't want to -- you know.

17 CO-CHAIR CASEY: Well, why don't we do
18 this? Let's do public comment. We can do next
19 steps, and let me ask each individual that wishes
20 to stay to maybe after we've done that, spend a
21 minute or two just reflecting from their own
22 perspective on what we did well and what we could

1 do better. I don't just mean working as a group,
2 because I think we did that well, but in terms of
3 our thinking, okay? Would that work? Yes.

4 MS. NACION: So Yetunde's just coming
5 around to discuss the standing committee terms.

6 MS. OGUNGBEMI: Oh yeah. Please don't
7 leave yet.

8 MS. NACION: So don't leave yet.

9 CO-CHAIR CASEY: Right, right. We're
10 not dismissing you. We're just saying if you
11 have to -- if you have to go, you have to go.
12 But we finished early at least there. Let me ask
13 Katy to -- and the operator to see if there is
14 anyone on the line that wishes to make public
15 comment at this time.

16 OPERATOR: At this time if you would
17 like to make a comment, please press star and
18 then the number one.

19 (No response.)

20 OPERATOR: There are no public
21 comments from the phone line.

22 CO-CHAIR CASEY: Okay. So thank you

1 operator, and we want to keep our members on the
2 phone too, if we can, to listen, so -- for next
3 steps. But before we do that, I've been asked to
4 go around the room and ask each of you to read
5 your term limit.

6 MS. OGUNGBEMI: Yes. Please say your
7 name first and then read your term limit.

8 (Off microphone comments.)

9 CO-CHAIR CASEY: Anyone else?

10 MEMBER WIEFERICH: Must be me. Jeff
11 Wieferich, two years.

12 MEMBER BECKWITH: Samira Beckwith,
13 three years.

14 MS. OGUNGBEMI: Thank you. There were
15 an even number of both, so you picked them.
16 Thank you all.

17 CO-CHAIR CASEY: What else do we need
18 to talk about from a housekeeping standpoint,
19 Peg?

20 MS. TERRY: Just next steps.

21 CO-CHAIR CASEY: Next steps, me and
22 Katy?

1 MS. NACION: So I'm just going to
2 briefly go over the next steps. These are our
3 upcoming activities. We will have a post-meeting
4 call on March 7th, and the draft report will be
5 posted for public comment on March 30th.

6 And if you do need to get a hold of us
7 for any reason, any questions or comments, please
8 feel free to email or call us. These are our
9 contact information. We also have the project
10 page here, as well as the Sharepoint site.
11 That's it.

12 CO-CHAIR CASEY: Well let me ask,
13 because I think the public comment will be just
14 about the measures, am I right? They will not
15 comment on the gaps. That's our own internal
16 discussion. Am I right or does that -- am I
17 wrong?

18 DR. TERRY: Well, it will be what we
19 need to finish. So we could do related and
20 competing, you know. We could do anything.

21 (Off microphone comment.)

22 DR. TERRY: Oh right, right.

1 CO-CHAIR CASEY: So gaps needs to be
2 in the report, and could you put that back up
3 May, about the time line? So post-meeting call
4 would probably -- it's two hours. It looks like
5 what -- what would we do during that? It would
6 be just going through the seven measures to recap
7 where we are? Would we be doing any specific
8 work before that or during that?

9 DR. TERRY: So there are some
10 information we're waiting for possibly from Larry
11 Kleinman and maybe --

12 CO-CHAIR CASEY: Right.

13 DR. TERRY: Yeah. So there may be
14 that information coming in, and so we'll discuss
15 that, and the other issue is related --

16 CO-CHAIR CASEY: So in other words
17 anything that comes in, and then you're going to
18 do the -- we have the related measures listed out
19 or not?

20 DR. TERRY: We do, we do. Some of
21 them may -- yeah. We'll talk. Some of them may
22 not be existing measures in the future, but yes,

1 they still are related today.

2 CO-CHAIR CASEY: Okay. So I would
3 suggest for the benefit of the -- and I'm sure
4 you're doing this, but just whenever you get
5 information that you think is useful to us, send
6 it out to us so we can work on it.

7 DR. TERRY: Absolutely.

8 CO-CHAIR CASEY: And then the question
9 about gaps, knowing that there would still be
10 time before the public comment.

11 My suspicion is Gerri and Rich, you
12 help me out. I'm wondering about how or if we
13 should have another conversation about gaps after
14 we've allowed the dust to settle on the day. I
15 don't mean to make this a long drawn-out thing,
16 but is that in scope?

17 DR. TERRY: Well, I think we can do
18 it. I'm not sure exactly what you mean, but I
19 think we can look at that. It's part of what
20 we're doing. It's important that we look at the
21 future and where you're going, and I know you've
22 started that, in that off cycle work so it's a

1 good --

2 CO-CHAIR CASEY: So we could get some
3 insights from today. You can synthesize that.

4 DR. TERRY: Right, right.

5 CO-CHAIR CASEY: And we'll probably
6 have a few more insights from our roundtable, and
7 then we can look at that and say yay or nay, we
8 want to talk through it, right? Yes Ellen.

9 MEMBER SCHULTZ: I just wonder whether
10 there might be some sort of synergy with the
11 Measure Incubator effort that NQF has going on.
12 You know, there hasn't been a convening of that
13 group in a little while.

14 So, you know, maybe that's something
15 where this Committee has something to share, be
16 it highlighting some gaps or some, you know,
17 thought experiments or whatever that we would
18 want to engage a broader community of measure
19 developers that are looking for guidance and also
20 looking for help.

21 How did they overcome some of the
22 barriers that we've talked about here, where we

1 want to get to that next level of measures but,
2 you know, the data's over here and the challenges
3 of testing are over here. So that might be
4 another place where we could engage.

5 CO-CHAIR CASEY: Yeah. It's a good
6 point and I wonder if the comments Gerri and I
7 sort of made to Dr. Agrawal this morning is
8 apropos to this too, which is this is, as we've
9 identified, Brenda, you know, started it, that
10 this is a high stakes issue and we really feel
11 like we don't -- we're not there yet and we need
12 to get it right.

13 So the question is, and Rich you're in
14 the high place, do we elevate this to a point
15 where it's part of a pretty direct conversation
16 with the incoming administration about what we
17 can do better.

18 I mean I think we've done a great job,
19 but obviously, no offense, the measure developers
20 are still back here trying to sweep things up and
21 don't put that down on the record, but I think
22 you all know. So what do you think Rich?

1 MEMBER ANTONELLI: So Ellen, I don't
2 think that I've ever heard you say anything that
3 I don't resoundingly agree with. So in fact we
4 just got pinged from the incubator. So there's
5 been a series of requests coming out from the
6 incubator to folks that are actually doing some
7 work in this arena.

8 So I think one of the things that we
9 could ask of the NQF staff is really, and I'm not
10 going to misuse this word, "coordinate" across
11 all the various activities within the NQF itself.
12 So when we're agonizing over a measure that the
13 spirit is right but the implementation really
14 feels like it's falling short, it would be great
15 to know that there's something in the pipeline.

16 I think that will give us some clarity
17 when we're thinking about harmonization or
18 parsimony or, you know. I'm going to vote for
19 this even though it sucks kind of thing. But you
20 know, let's give it six months and then --

21 So I think that kind of transparency
22 within NQF is really important. I am anxious

1 about that point that you raised about
2 conversations with the incoming administration.
3 We should all be very mindful that the NQF has
4 contracts with CMS, and I've had two
5 conversations at meetings that CMS staff have
6 called, and in those meetings I said so I have a
7 question and they said we can't answer it.

8 So we are in a period now where I
9 think we need to invoke the Irish Serenity
10 prayer. The things that this group can control
11 could at least be conversations within NQF, and
12 then we can be mindful about what we go outside.
13 But again Ellen, I think the observation about
14 what's in the incubator and what are they
15 soliciting will probably really whet a lot of
16 people's appetites around this table, because
17 frankly some of the stuff that I've seen is kind
18 of moving across that bridge that you pointed out
19 this morning.

20 CO-CHAIR CASEY: And you know, you've
21 always agreed with me but you've never quite
22 asked me what I think of the Patriots, the Red

1 Sox, the Bruins. So don't do that, okay. Elisa.

2 MS. MUNTHALI: Thank you so much for
3 your comments. This is something we have been
4 talking about and have started to do through part
5 of what Marcia talked about before, the feedback
6 loop. You didn't see it earlier, but
7 intentionally our colleagues from the incubator
8 were here to hear your gaps discussion.

9 That is because we do recognize that
10 we do need to inform each other, upstream,
11 downstream, so that we're linked better
12 internally.

13 CO-CHAIR CASEY: So Ellen, thank you
14 for bringing that up. That's a really, really
15 good idea. Why don't we just go around the horn.
16 We started over here, so let's start over here
17 with Samira, and tell us what worked and what
18 didn't and, you know, you can say the food was
19 great and, you know, the diet title like diet
20 ginger ale, or you can say, you know, I wish we
21 had done this or that. So give me your thoughts.

22 MEMBER BECKWITH: Yeah. Well, I

1 thought that two calls that we had prior to the
2 meeting were very helpful, and I don't know that
3 much more could have been done before this
4 meeting. But I feel much better educated after
5 this first meeting. So I thought everything was
6 very, very helpful, and I look forward to the
7 future.

8 CO-CHAIR CASEY: It's kind of like
9 swimming for the first time, right.

10 MEMBER BECKWITH: Yeah.

11 CO-CHAIR CASEY: You can watch the
12 video all you want, but until you're thrown in
13 the pool --

14 MEMBER BECKWITH: Exactly, that's
15 good.

16 CO-CHAIR CASEY: But we don't let
17 anyone, you know, well I didn't say that.

18 MEMBER BECKWITH: Well --

19 CO-CHAIR CASEY: Get their hair wet,
20 how's that? Jeff.

21 MEMBER WIEFERICH: For me, just I have
22 a much better understanding about what the

1 Committee does, what the purpose is and, you
2 know, getting to go first and not really knowing
3 what to talk about is fun, so I appreciate that.

4 CO-CHAIR CASEY: Well, we didn't even
5 -- we thought you were an expert. I mean it
6 didn't, you know.

7 MEMBER WIEFERICH: You're a little
8 kind, but thank you.

9 CO-CHAIR CASEY: No. You did very
10 well. I mean it's like, you know, you show up
11 and you do the work, and that's it.

12 MEMBER WIEFERICH: Makes me appreciate
13 even more all of the work the staff does, because
14 without the staff and all the stuff that they
15 did, this would have been impossible really. The
16 volume of information for each of these measures
17 is overwhelming. So thank you to the NQF staff.
18 That worked really well.

19 And I was just thinking how the phone
20 calls actually worked well as well, I think. And
21 to a certain extent I think we made many of our
22 decisions already at the phone call level, and

1 this was more of a ratification of it. It's nice
2 to hear the further fine points of justification.

3 I don't have a good sense of how many
4 votes were swayed, based on the conversation
5 today that we're a step firmly established on the
6 phone calls. So that might be something to look
7 into, you know, more phone calls.

8 CO-CHAIR CASEY: Well, I think the
9 staff is always trying to take the temperature of
10 the group, you know, just in terms of is this
11 going to be, you know, you've done these -- I
12 forget what they call them, where you put
13 everyone in the room, modified Delphi, where you
14 know, you end up with two and one, two, three,
15 you know, it goes all the way across to nine.

16 They're looking for, you know, that
17 type of situation. But I think most of the time
18 we land in pretty much the same place. We got
19 close on a couple of things, but I think it just
20 helps set the tone for the meeting. So thank you.

21 MEMBER WIEFERICH: And just one last
22 comment on sort of gaps, because I'm not sure

1 you're going to make it around again. That's to
2 look at, as we talk about care coordination
3 across the continuum, in fact we had to expand it
4 out to folks that are not eligible providers; we
5 even need to get into the community and beyond
6 even.

7 There's a similar issue around
8 interoperability. So I'm on the interoperability
9 work group, and then -- and really the challenge
10 is how can you -- how can you create
11 interoperability measures that actually drive the
12 adoption of interoperability, and sort of what is
13 it, how much interoperability is sufficient for
14 where you are in this continuum, because if
15 you're down in the home and community-based
16 service realm, your interoperability may be very
17 well served by fax and PDFs if you want.

18 But if you're a big network with an
19 integrated EHR, then your interoperability is
20 huge and very complex. So that to find a measure
21 that meets all of those needs I think is going to
22 be a challenge, but the important thing is that

1 we need to align interoperability measures with
2 what we're doing here around care coordination,
3 because care coordination extends to places that
4 interoperability doesn't, and I think the two
5 have to go together for this to work.

6 CO-CHAIR CASEY: Yeah, and if you
7 remember, I don't know if you recall, in the
8 preferred practices we actually talk about that.
9 We don't use the term "interoperability," but we
10 describe what we mean by that in real terms, and
11 we also aspire to having one plan of care, not 20
12 so --

13 MEMBER ANTONELLI: So in my training
14 and residency in the neonatal ICU I always
15 thanked the nurses. So the equivalent is to
16 always thank and acknowledge the NQF staff. You
17 guys are absolutely amazing.

18 (Applause.)

19 MEMBER ANTONELLI: The volume of
20 information, the number of moving parts and
21 putting it together in an elegant way that allows
22 us old people to figure it out. I thank you from

1 truly the bottom of the my heart. That was
2 great. But this is the first time I'm ever going
3 to say this, but that -- and it was inspired by
4 your comment in the hall.

5 I hope the newbies didn't slow things
6 down, and I want to take that head on because to
7 the contrary, every single new person here, talk
8 about hitting the ground running. It was just,
9 you know, I think your analyses were great, the
10 questions were insightful, and frankly Don I
11 think from my perspective bringing this new blood
12 in here and the two people that I know the most
13 from outside of this are those two people over
14 there.

15 This is exactly the kind of voice that
16 we have to bring into this. So and then I kind
17 of want to end with a sobering comment. I feel
18 like this group and others, but this group in
19 particular, we have I think an obligation to
20 inform the field of care coordination and care
21 integration. I'm going to keep using those two
22 terms.

1 What do I mean by that? It's painful
2 to sit through a measure that you know isn't
3 going to measure up, but somebody's put a lot of
4 work into that. I won't tell you which one, but
5 at the steering committee last month, when the
6 resist flag was being hung outside that window,
7 just saying, somebody had put like two years of
8 work into a measure and not a single person
9 around the steering committee said right on.

10 In fact, we thought that it was kind
11 of misconceived, and that's a hard message to
12 deliver. Not because it wasn't a good measure,
13 but it wasn't really directionally where we want.
14 So I actually would put some pressure on us to
15 let -- the sooner we can do that internal
16 analysis of existing measures, and I'll look to
17 the NQF staff, the more interconnected we can be
18 within the NQF's walls to know what's in that
19 pipeline, the sooner we can start pushing things
20 out.

21 In an ideal world, PCPI would have
22 come in today and say we're going to withdraw

1 these measures, because we've got a new one, or
2 we've adopted -- we've adapted that one to
3 measures such as us because you guys gave us the
4 direction. So yes I'm challenging us. But I
5 think to the degree that the NQF has this august
6 position to inform the field, we need to do that.

7 I would argue that it should be a
8 performance measure for the standing committee as
9 to the number of measures that we evaluate that
10 are directionally appropriate. I hope that
11 people can consider that the polite challenge
12 that it's intended to be.

13 CO-CHAIR CASEY: So taken. Emma.

14 MEMBER KOPLEFF: I really enjoyed
15 being with you all today and having some great
16 brains in the room. I think the fact that we
17 were so thoughtful in not accepting, even though
18 we trust and value our predecessors on this
19 Committee's judgement, it's a testament to where
20 performance measurement has gone and this group.

21 So even though sometimes it feels like
22 a snail's pace in terms of the types of measures

1 we're getting in front of us and that metric that
2 you speak to, to me it was heartening that we
3 were able to take a critical look and a
4 thoughtful look at not just what's up to snuff
5 and what's not, but how do we make it better.

6 I thought just the spirit of this
7 group and thanks to the staff and our co-chairs
8 for supporting that was very collaborative,
9 congenital, good sharing of ideas and information
10 and that can be a challenge when you throw people
11 together.

12 I appreciate the in-person look at you
13 all. While I agree the pre-work over the phone
14 was a good start, I think there could be some
15 efficiencies there in terms -- I think the most
16 valuable -- for me the most valuable takeaway I
17 got from the phone calls was more the direct
18 questions for the developers, so the developers
19 could come in ready to respond to those, in terms
20 of reviewing all the measure specs and everything
21 like that.

22 I mean it's hard work and this group

1 has shown they're dedicated. It's hard to do it
2 as a group, you know, and staff has supported us
3 and urging us to do our homework so --

4 CO-CHAIR CASEY: Well, and just be
5 mindful of the fact that that doesn't occur in
6 the context of public scrutiny, whereas this
7 meeting does.

8 MEMBER KOPLEFF: That's true.

9 CO-CHAIR CASEY: So we do have to step
10 through that. By the way, after you walk out the
11 door, there will -- none of you will be newbies,
12 so you know, get over that. It's gone.

13 MEMBER KOPLEFF: And I apologize for
14 leaving early but I've got a kid with a fever.

15 CO-CHAIR CASEY: Thank you. Thank you
16 very much. Brenda.

17 (Off mic comment.)

18 MEMBER LEATH: I just want to say that
19 it's been honor to be on this standing committee,
20 and to have an opportunity to work with everyone
21 around something that's so very, very important.
22 I really meant it when I said that care

1 coordination is an area that ultimately gets
2 pushed aside, doesn't get the -- its just due.

3 So I am happy that an organization
4 such as NQF is embracing a focus and dedicating
5 resources and commitment and time toward trying
6 to develop measures in this area. I think one of
7 the gaps, if we're going to look at the
8 engagement of community-based care coordinating
9 agencies and organizations in this process, I
10 think many of them will need certain kinds of
11 tools, and I think Rich that's what you were
12 alluding to.

13 That's going to be very critical if
14 you want their input, in helping to develop
15 measures that might be meaningful for their
16 operations. And you know, lastly I just want to
17 compliment the staff on all the preparatory
18 activities and the organization of all the
19 meetings that we've had, because it is very
20 impressive to get all of the information
21 distilled and, you know, in a format that one
22 could readily review and begin to cogitate on it.

1 I guess I do have one last thing, and
2 I want to say that I like the dynamics of this
3 group because everybody's been very receptive to
4 very different viewpoints. I think that that's
5 critical as we try to move forward. So thank you.

6 CO-CHAIR CASEY: Godmother.

7 MEMBER MICHAEL: Sure. I'm going to
8 be very brief. I think that the staff and the
9 prep work were great. The sharing of ideas is
10 great. My only wish is that sometimes we get
11 down tangents, and I think we need to come back a
12 little quicker, because we do have a lot of work
13 to do. We need to evaluate more measures, I
14 think. As Terry or Rich was saying, we need to
15 be able to get through more of them and we need
16 to really use this time for that. But it's been
17 a great experience.

18 CO-CHAIR CASEY: Thank you, Karen.
19 Ryan.

20 MEMBER COLLIER: I appreciate that I
21 wasn't quarantined, and apologize for all the
22 Kleenex I went through. I was going to steal a

1 box off the front desk, but anyway I wanted to
2 echo the thanks and appreciation to the staff. I
3 felt like the meeting and the prep work was very
4 streamlined. Not only that, but the process is
5 pretty transparent and somebody can sort of fold
6 into it and try to follow the algorithms and
7 approach measure assessment in a way that's
8 consistent, and take away some of the potential
9 subjectivity and make evaluations as objective as
10 possible.

11 So I think that that's a great
12 testament to the process in the way it's been
13 developed over time. Don, I really appreciated
14 your level-setting at the beginning, because I
15 think I did really struggle with feeling some
16 level of, you know, hope that we would be able to
17 get to a higher level of measurement than we can
18 right now with where we're at, and I think you
19 did a nice job of sort of helping calibrate us to
20 where the current state of the measurement is,
21 and it allowed me to be a little bit less hard, I
22 think, on some of the measures than I sort of

1 felt like coming in otherwise.

2 I wanted to mention a couple of other
3 things. I personally feel like -- I was
4 wrestling with the tension between while I was
5 reviewing measures, approaching it like a peer
6 reviewer and wanting to make a bunch of
7 constructive feedback to the measure developers,
8 versus just an assessment black and white, here's
9 kind of where things are at.

10 I don't know if that feeling
11 represents an opportunity to have more dialogue
12 with measure developers, so that folks like, you
13 know, the second half of the day maybe could come
14 in and I don't know if they felt surprised by the
15 result or not but try to mitigate some of that.

16 And so that was just one sort of
17 reflection I had. Lastly, I'm very energized by
18 the work that the group is going to be doing
19 outside of the measure voting process that we did
20 today really to the gaps in care coordination. I
21 think that to keep ourselves sort of at the
22 cutting edge and avoid becoming, you know, more

1 stale because of the current state of where our
2 data streams are and where the state of current
3 care coordination measures are, thinking about
4 how we can create a vision for the future of care
5 coordination measurements.

6 I'm very energized by being able to be
7 a part of that with this group, and I think that
8 that will do all of us good for the field.

9 CO-CHAIR CASEY: Well let me just
10 highlight one thing you said, because I think
11 each member of the Committee still has the
12 ability, either directly or through whatever
13 organization they're involved with, to
14 participate in the public comment and give that
15 type of feedback.

16 So but here obviously we're doing the
17 business of, you know, getting the measure
18 endorsement process through the hoops, and it's a
19 challenge in the beginning, but thank you.
20 Ellen.

21 MEMBER BECKWITH: Sure. So thinking
22 a little bit more broadly about measurement and a

1 lot of conversations in recent years about having
2 too many of the wrong kinds of measures. I know
3 NQF has recognized that and called it out in part
4 of our strategic plan. How do we reduce the
5 number of measures and get closer to measuring
6 what matters?

7 So I wrote down a note to myself at
8 the beginning of the day, which was the question
9 that if we keep using the same process and the
10 same criteria to evaluate measures, can we really
11 expect to get a different outcome? Can we expect
12 to get something other than 700 measures, a lot
13 of which are on process, on particular disease
14 conditions or care settings, sort of a stream of
15 minutiae.

16 But I'm really rethinking that after
17 today, because we had, you know, even using the
18 same process and the same criteria, we had a
19 really rich discussion, and we had a lot of
20 challenging going on in the room and yet we did
21 it in a way I think that was positive and
22 constructive to developers.

1 And we did get a different result, all
2 right. We have a lot of measures that are coming
3 up for maintenance review that didn't pass, you
4 know. Whether that's good or bad on an
5 individual measure, it's different from what I
6 expected even going through the same process. So
7 it's food for thought, I think, that for NQF,
8 from a bigger picture thinking about how you go
9 forward, how do you keep pushing the field and
10 measurement forward as a whole, you know.

11 Where do you need to work within that
12 existing process, and where is there room where
13 some changes need to happen to processing
14 criteria? We heard a lot in the room today
15 repeatedly about bringing in the patient and the
16 family voice. I believe really strongly in that,
17 and I think one really important way that that
18 could happen is bringing them in to some of those
19 big picture thinking about the process and about
20 the criteria.

21 That had a huge ripple effect across
22 a lot of different areas, and maybe care

1 coordination is a place to pilot that a little
2 bit.

3 CO-CHAIR CASEY: And you're starting
4 hard on the preferred practices, right?

5 MEMBER BECKWITH: Yes.

6 CO-CHAIR CASEY: Good, thank you.
7 Chris.

8 MEMBER DEZII: Yeah. I guess it's
9 sort of like having a patient say what are you
10 people doing here, right? The NQF incubator, I
11 think, would be a nice vehicle. It was nice that
12 they were here for the gaps. But I don't know if
13 they operate via an RFP process, or at least
14 identify areas like care coordination as areas
15 for folks to submit, you know, measure ideas,
16 with a nice template and following the template.

17 I don't think anybody did a grading of
18 the evidence, and I think our dialogue can
19 understand why nobody graded the evidence. I
20 think they should. What else do I have? My
21 tolerance threshold was tightened a little bit
22 today and that's cool. You know, I came in

1 looking -- you know, I really do believe in that
2 bridge and you know, but this was -- this was too
3 hard to overcome, some of these challenges.

4 I had a technical challenge with the
5 -- I didn't realize my work group wasn't going to
6 be here, and I had a technical challenge in that
7 I really didn't know what their comments were
8 until ten minutes before I started speaking
9 thanks to Katy, because I couldn't access the
10 stuff. So if I appeared to tap dance, that's
11 what I was doing.

12 So thanks for bearing with me. That's
13 all. Ryan, we better advise the measure
14 developers, okay. I think that's part of what I
15 think our job should be. Those are my bullets.

16 CO-CHAIR CASEY: Great.

17 MEMBER ANTONELLI: Don, I apologize.
18 I have to jump in here because I understand what
19 you mean by peer review. Maybe you guys should
20 speak to that, because I think there --
21 considering that we're sitting in a position of
22 judgment, it's a little bit different to advise

1 and then potentially have to be in a position of
2 saying okay, this measure reflects input that I
3 gave the developers six months ago.

4 So there could be some muddy waters in
5 there or maybe I'm wrong. But I guess I just
6 can't let this piece lie without it being openly
7 discussed, because this isn't a peer review
8 process.

9 CO-CHAIR CASEY: You want me to answer
10 that?

11 (Off mic comment.)

12 CO-CHAIR CASEY: Well let me get to
13 the rest of the group, and then I'll address
14 that, okay. I'll try to. Charissa.

15 MEMBER PACELLA: So I was not exactly
16 sure what to expect, but it was a great day with
17 lots of smart people in different places. I look
18 forward to the idea of having care coordination
19 measures that span spectrums and are very
20 patient-centered. It's a huge challenge to come
21 up with those things and I think they're, you
22 know, driving new things.

1 I was just a little bit disappointed
2 not to be able to love anything, you know. It's
3 right there, and then my only other thing is
4 could preferred practice somewhere, could
5 somebody tell us like exactly where it is or put
6 the link in an email, because that would really
7 help.

8 And then I mean I have lots more
9 thoughts about care coordination that should
10 include people like radiologists with findings in
11 addition to patients and everybody else, and just
12 areas we haven't even really gone to very much,
13 and that's it. I hope there's a way for the
14 measure developers to get some additional
15 feedback prior to a day like today, even if it's
16 not from within this group.

17 CO-CHAIR CASEY: So Charissa, let me
18 help the staff, because I think some of them may
19 not know this perfectly well, but there's sort of
20 two documents. One is the original preferred
21 practices, which I think came out in a tome about
22 2010, and then probably in '14 I think in a slide

1 set or some sort of white paper we sort of
2 upgraded.

3 I would recommend you read both,
4 because you can see how that's evolved, and I
5 certainly think these I hope will continue to
6 evolve, because I do think it sets the stage for
7 things like peer review, which I'll address in a
8 moment. But Shari.

9 MEMBER ERICKSON: Well thanks. I'm
10 really just very honored to be able to
11 participate in this, and I appreciate it on a
12 variety of levels as, you know, in my day job as
13 well as an individual who has coordinated care
14 for my family members, and just in terms of
15 personal interest and coming from my background
16 from being at NQF as a staff member.

17 So I do sincerely appreciate all the
18 work the staff has done, and I have staffed
19 committees at IWIN (phonetic) before that, before
20 I came here and then here and now at ACP. So I
21 get and empathize with all of the work that you
22 go through and appreciate that.

1 A couple of things I just wanted to
2 pick up on, and you know, Ellen, everything you
3 said just really resonates with me and I have to
4 say I couldn't agree more, that the patients need
5 to be engaged and however NQF can figure out how
6 to do that. I know we're trying to do that more
7 at ACP in our work.

8 We have certification partnership now.
9 We do have patients that are on our clinical
10 guidelines committee now, and I know we're trying
11 to think through how to do that more with our
12 performance measurement committee as well. So I
13 just -- I strongly encourage that we try to
14 figure out how to do that, because I think it
15 would really --

16 It's hard though. I don't have to go
17 down a whole soliloquy on that, but it is
18 challenging for a variety of reasons. Okay.

19 (Off mic comment.)

20 MEMBER ERICKSON: Okay, great, great.
21 The other thing, you know, because I do -- I
22 guess part of my reasoning for going into this is

1 I do think as someone who's watched this quality
2 movement for a while now, you know, care
3 coordination measures and measures that get at
4 patient-reported outcomes and experience, moving
5 beyond, although I recognize the value in the
6 CAHPS survey, has just got to be the way of the
7 future, I mean really.

8 And to the extent that NQF can push
9 the field in that direction, I think that would
10 be helpful. Just related to today, I feel really
11 good about where we landed. I know -- I didn't
12 really expect us to land in a place of saying, of
13 voting down some of these measures either, and I
14 think -- and I feel kind of bad about that in a
15 way in terms of the measure developers perhaps
16 being surprised by that as well.

17 But I think, you know, and I hear
18 about it from our members in terms of the
19 measures that they're asked to report on or their
20 entities are asked to report on, you know, these
21 are things that would drive them crazy and
22 wouldn't get them to the place where they want to

1 be. And so, you know, I think we landed in the
2 right place, as challenging as it might be, and I
3 agree with you, the process landed us there in a
4 way that I wasn't expecting.

5 You know, I do think informing the
6 field, that you brought up Rich, is really
7 important and moving that forward. Part of it,
8 you know, coming from a specialty society in
9 medicine, you know, ACP has been a pretty strong
10 supporter of NQF and the process for really since
11 its inception.

12 But we're not -- we're a minority in
13 many ways these days among the medical
14 specialists, specialty societies. We don't
15 develop measures so perhaps that's why we are
16 there. But you know, a lot of other societies
17 have been really frustrated by the process,
18 because as we were talking about, you go through
19 years of development and only to have it sort of
20 shot down, so to speak, in the committee process.

21 I know that NQF has made a lot of
22 improvements in the process, which I think are

1 fantastic in trying to move forward and the
2 incubator and all of that, and just you know, I
3 think continuing in that direction is the way to
4 go. But you know, there's still a ways to go
5 there because it does concern me that, you know,
6 we could have measures just go, landing in
7 reporting programs that really haven't had an
8 external entity really look at the evidence and
9 review it from a multi-stakeholder perspective.
10 It is inclusive ideally of the on-the-ground
11 users of the measures and the patients and
12 families too so --

13 CO-CHAIR CASEY: Well and you do
14 generate guidelines, which is the foundation for
15 performance measures, and so you're --

16 MEMBER ERICKSON: Yes, yeah.

17 CO-CHAIR CASEY: Barbara, we're going
18 around the room talking about what went well,
19 what we liked, what we had to wish we'd hoped for
20 that we didn't achieve. I'll let you think about
21 that for a moment, because I want members of the
22 staff to weigh in to with some of their thoughts.

1 So Peg, you had something you wanted to say.

2 DR. TERRY: Well, I just really wanted
3 to thank everybody for your participation today
4 and your engagement. It's really been a very, I
5 think a good day and a lot of good discussion.
6 In particular, I want to thank our co-chairs, for
7 Don and Gerri, for all their work and we work
8 with them offline and there's a lot of work, you
9 know, that's happened before the meeting and more
10 to come. So again, thank you all for today and
11 the work.

12 MS. MUNTHALI: I just wanted to echo
13 what Peg said. It's a lot of work for staff, but
14 we know it's a lot of work for you, and you have
15 other jobs and we just really appreciate all the
16 time and effort you put into this work. So we
17 can't thank you enough.

18 I just wanted to thank our team as
19 well, and going back to we're noting all of the
20 comments. We really appreciate the feedback. We
21 received quite a bit of feedback and criticism
22 about, you know, developers' inability to come to

1 us early, enough for us to give feedback.

2 Something we did institute a few years
3 ago is technical assistance, which a lot of
4 developers and committee members and others that
5 are engaged in our process are not quite aware of
6 it, and it's part of our communication challenge,
7 to let them know. As I was talking to PCPI here,
8 I said you know, it would be great if you guys
9 came to us first. We cannot guarantee a pass by
10 the Committee, but we can tell you the likelihood
11 of something going forward or not based on our
12 criteria.

13 And so they, you know, they will come
14 to us early. The other thing is, you know,
15 trying to get the patient voice around our
16 tables. It is difficult. As you can tell, the
17 information is very dense. It is dense for many
18 people, clinicians, those that are
19 methodologists, those that work in measurement.
20 It's a lot of information.

21 It is another communication challenge,
22 education challenge. We're trying to work on how

1 do we get the right voices, the mix of voices
2 around the table? So this is a commitment we do
3 have. We are working with CMS as well to, you
4 know, make sure we know that the challenges are
5 there with MIPS and MACRA, and there are some
6 requirements that don't have to -- for measures
7 that don't have to come to NQF.

8 That means that, you know, they may
9 not go through a multi-stakeholder review to
10 review the evidence or the testing. CMS
11 recognizes that it is an issue. We are in
12 constant communication and discussions about, you
13 know, what is the viable path forward.

14 So these are things that we are
15 discussing, trying to work on. We'll be in touch
16 with you throughout the process, but we just
17 wanted to thank you for your thoughtfulness.

18 CO-CHAIR CASEY: Thank you, Elisa.
19 Dawn, are you still with us?

20 (No response.)

21 CO-CHAIR CASEY: Dawn was on the
22 phone. Are you muted, Dawn? We don't have

1 Lorna, and I think Marcia was just on for a short
2 while. So before I turn to Barbara, let me ask
3 the rest of our team if you want to make any
4 pronouncements about how you thought things went.

5 Again, you did a great job and we
6 really appreciate it, and as I told the newbies
7 to care coordination, it's when you work at NQF
8 and you now become staff for the Care
9 Coordination Standing Committee, that's a big
10 rite of passage within NQF. So you've made it.
11 You're cool. Barbara, do you want to --

12 MEMBER GAGE: I'm sure it's already
13 been said, but the materials that you guys
14 prepare are very helpful. I've been on the other
15 side with the measure development and it's a
16 pain to put the submission materials together.
17 But you guys really brought things down to -- in
18 a nice summative level and included the resources
19 we needed to look further into the details. So
20 thank you.

21 CO-CHAIR CASEY: Karen, do you want to
22 chime in? You're sitting back there. You're

1 always great to have in the room with us,
2 especially when we get stuck on things. But you
3 want to say anything?

4 (Pause.)

5 MS. JOHNSON: I was just going to say
6 I've been here a little over five years now.
7 Care coordination was my first project here, and
8 some of you I remember from five years ago. But
9 most of you I think are new since that time. So
10 it's been really interesting.

11 I'm kind of going back in my mind from
12 what I heard today compared to what we did back
13 in 2012. So it's really interesting to see the
14 progression and the evolution of the committee
15 itself, as well as, you know, just measurement
16 science in general. So thanks for letting me
17 listen in.

18 CO-CHAIR CASEY: Thanks, and our
19 friend in the back, our audiovisual expert,
20 you've got everything down, right? So thank you
21 very much. Let me have a few quick comments.

22 One is I do think today, and Karen you

1 can back me up on this, was further evidence that
2 NQF's hard work to bring to bear the importance
3 of science in the measure development process is
4 really paying off, and I know it's been a journey
5 from where we started, and I won't say anything
6 pejorative.

7 But it is now rigorous. I'm not
8 saying anything pejorative about the way it was
9 done in the past, but it's rigorous in the right
10 way and it requires us to really think hard about
11 the application of evidence, and I always say
12 there are two levels of evidence to a measure.

13 One is the evidence supporting the use
14 of the measure and the rationale, and I think the
15 next phase of this is, along with what Brenda was
16 talking about, which is when you say measures
17 that matter, prove it. Prove it that they did
18 matter, that there was an impact, that lives got
19 better by the use of the measure.

20 I think that's kind of the next phase
21 of where we're always trying to go. It's kind of
22 like the Mount Everest of where we need to be.

1 That's a challenge, as we know, for things that
2 don't have big randomized control trials like the
3 use of ACE inhibitors for heart failure that
4 reduce morbidity and mortality.

5 So I applaud NQF for really staying
6 the course in a very complex environment to get
7 this forward. I also think that the measure --
8 and again, I don't want to dwell in specifics
9 here, but I will say that it used to be,
10 relatively speaking, less challenging to be a
11 measure developer, and Barbara I think you'll
12 agree with me.

13 Measure development should really be
14 much more of a team sport. I always say when
15 people say there's not enough money, I mean I say
16 wait a minute. You've got the providers over
17 here; you've got the health systems here; you've
18 got the IT vendors here and you've got the
19 insureds here, and you're saying we can't work
20 together to get it right?

21 So that's a big aspirational, but it
22 seems as though just asking groups who are

1 resource-constrained to keep trying to do the
2 same thing is a fool's errand without them being
3 at the table. They're extremely talented people
4 and I know they're trying. But it seems as
5 though we have to push the envelope, though, on
6 this being a high stakes opportunity to change
7 the game, so to speak.

8 I think this conversation just adds to
9 the thinking about why that's important. I
10 think, you know, I apologize for not being on the
11 two calls. But the thing I would have liked more
12 of would have been just to hang out with you,
13 because I always find that through these
14 committee meetings, getting to know people over
15 time it's been a lot of fun.

16 You know, we get to know each other in
17 the meetings, but I think -- and it's hard,
18 because some people come in the day of and leave.
19 But I just look forward to working more with you
20 and getting to know you better, and I appreciate
21 the chance to be the chair.

22 I know Gerri would probably say the

1 same exact things that I would say. She's a real
2 fantastic person and I'm really always in awe of
3 having her around. So I'm going to speak a
4 little bit for her and say that she and I both
5 agree that this was a great, a great new phase
6 and we look forward to working hard together.

7 So that's it. Did we miss anything?

8 FEMALE PARTICIPANT: I don't think so.

9 Thank you.

10 CO-CHAIR CASEY: Okay. Thank you.

11 FEMALE PARTICIPANT: Thank you.

12 CO-CHAIR CASEY: Thank you very much,
13 great.

14 (Whereupon, the above-entitled matter
15 went off the record at 4:50 p.m.)
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In the matter of: Care Coordination Standing Committee

Before: NQF

Date: 02-22-17

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