NATIONAL QUALITY FORUM

Moderator: Care Coordination
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OPERATOR: This is Conference # 93985077

Operator: Welcome everyone, the webcast is about to begin. Please note today's call is being recorded, please stand by.

Katie Streeter: Good afternoon, everyone, this is Katie Streeter with NQF. Thank you for calling in today to the Care Coordination Committee, we're group number two call.

Before we begin, staff here in the room with me will introduce themselves and then I will turn it over to Peg Terry, who's our senior director here.

Margaret “Peg” Terry: Thank you, Katie. This is Peg Terry and I'm here to walk you through the measure and I want to also welcome you to our second work group meeting of Care Coordination.

Yetunde Ogungbemi: My name is Yetunde Ogungbemi. Hello everyone, good afternoon. Thank you for joining us. I'm the project analyst for the Care Coordination Standing Committee.

Margaret “Peg” Terry: And my name is May Nacion, I'm the project manager for the meeting.

Katie Streeter: And we also want to welcome and turn the call over to Gerri Lamb, who is one of the co-chairs to this committee to provide some remarks.

Gerri Lamb: Sure, I'd be glad to. Thanks, Peg. Well good afternoon everybody and to those of you who were on yesterday's call as well – gluttons for punishment. It's wonderful to have you back again. I just wanted to just say a few words, then Peg is going to go through the plans for today's call.

We had a really good call yesterday, with all of the work group one members and several of you on as well. These calls are relatively new for those of you who have been on the standing committee before and I'm finding they're extremely helpful in anticipating some of the issues for the face to face meeting in a few weeks. As well as the chance to dialogue with the measure developers and also have them anticipate some of the questions that we may be bringing up.

So what we're going to be doing and Peg will go into this in much greater depth, is we're going to run through the process, you'll all have the chance to ask your questions and – Peg, how about you do that? And then if I have any comments afterwards, I'll make them.

Margaret "Peg" Terry: That sounds great, Gerri. I think what we're going to do is we're going to do a roll call now, see who's on the call. Yetunde?

Yetunde Ogungbemi: Hello, I'm going to do a roll call of only standing committee members that are supposed to join this call, and then I'll open it up for other committee members who are joining us as well. So is (Ryan Collor) on line?

(Ryan Collor): Yes.

Yetunde Ogungbemi: Shari Erickson?

Shari Erickson: Yes, I'm here.

Yetunde Ogungbemi: Barbara Gage?

Barbara Gage: I'm here.

Yetunde Ogungbemi: Emma Kopleff?

Emma Kopleff: Hi, I'm here.

Yetunde Ogungbemi: Lorna Lynn?

Lorna Lynn: I'm here.

Yetunde Ogungbemi: Ellen Schultz?

Ellen Schultz: Yes, I'm here.

Yetunde Ogungbemi: And (Jeff Wevricks).

(Jeff Wevricks): Here.

Yetunde Ogungbemi: Thank you. Are there any other standing committee members that have joined us that were not assigned to this call?

Richard Antonelli: Rich Antonelli is here.

Yetunde Ogungbemi: Thanks, Rich.

Dawn Hohl: Dawn Hohl.

Yetunde Ogungbemi: Thanks, Dawn. Is there anyone else? I think Brenda Leath's on the line, but maybe she hasn't joined in, so I'm just going to turn it back over to Peg and we can get started.

Margaret "Peg" Terry: Right, before we do, let's see if anybody from – any developers are on the call, we think that somebody is? Could you let us know that you're on?

Bob Rehm: Sure, hi. This is Bob Rehm at NCQA, we've got – I'll introduce my staff.

(Shauna Sandberg): (Shauna Sandberg).

Bob Rehm: (Shauna's) a new research scientist here with NCQA.

Margaret "Peg" Terry: Great. And is there anybody else from the university, I think (Suzanne) is on?

(Off-Mic)

Female: She may not have dialed in.

Margaret "Peg" Terry: Yes. I see – we understand that one of the other developers is not going to be on, but (Suzanne Lowe) is supposed to be on. (Suzanne)? I guess you have not called in. Can I just – (Suzanne)?

(Suzanne Lowe): Yes, I'm on.

Margaret "Peg" Terry: Oh great, great and – are you the only one on for the university hospital, Cleveland?

(Suzanne Lowe): Yes, it's just me today from the university hospital, Cleveland Medical Center.

Margaret "Peg" Terry: Great. Well thank you. So, I just want to kind of begin this and for those who were on yesterday, it's going to sound a bit like what we talked about yesterday. But the purpose of these calls – these work group calls are to allow the committee members to have some familiarity with the process and to sort of walk through the measures, looking at the five criteria. It's possible to try and get some dialogue with the developers, to sort of get their perspective to their questions.

And Gerri – we've been in touch Gerri, and Gerri has some really specific kind of ways that we should do it today based on yesterday's call, which I thought was very helpful. We have decided to as we did yesterday, just to do one measure. And if you want to ask questions after we finish this measure on anything of the other two measures in this particular group, we're – that's great. We can do that at the end. So the measure we're going to, as I call it walk through or review, is 3170 and it is a composite measure.

And so the way we're going to do this is we're going to start with it – I'm going to kind of, open up as we walk through each sort of section instead of say what we do in this section for these particular measures. And then I would like – so this would be helpful if I knew what committee member is going to review what part. So I thought if we could divide this up a little bit and see who would like to talk possibly evidence and opportunity for improvement or gap. Anybody on the call would like to do that? That's been assigned for this measure?

OK, I don't know if Richard Antonelli is on or (Ryan Collor)?

Richard Antonelli: I am on, but I've been up to my earlobes with Massachusetts Medicare and unfortunately I don't think I would do the measure justice by leading the discussion. I apologize.

Margaret "Peg" Terry: OK. And (Ryan), have you had an opportunity to look at the measure?

(Ryan Collor): I have, I'm new to the committee so I'll do my darnedest. I did get a chance to look through it.

Margaret "Peg" Terry: OK, that's fine. This is just a chance to sort of look at it, get a sense of it, and that's great. And then the next (way) that we can divide is by reliability and validity. Anybody want to be able to talk about? And this measure, let me just say – this is a composite measure. It's a little bit different than what we talked about yesterday. So as we get started, let's see if somebody wants to jump in and help us out with that section and then the last two sections are feasibility and usability as everybody knows.

So, this measure as I've said, is a little bit more complex – it's a new measure. We've not seen this measure before, and for the area of evidence – we're looking for what kind of support there is for this measure, what kind of evidence, what kind of research, what kind of guidance or guidelines there are to support this measure.

And usually what we do, this is just to kind of outline a little bit, is that we go over the title and the name of the measure and then go down a little bit; numerator and denominator and then talk a little bit about what you've seen or what's in the evidence for this particular measure. And again it's a composite measure so there are actually three parts to this measure. And probably should review that and then some of the questions – we'll get into some of the questions later; which is do the composites – components of the measure – is there enough evidence to support those as well as the overall composite?

So, (Ryan), do you want to just kick it off a little bit?

(Ryan Collor): Sure, I can get the conversation started and I was trying to digest everything in my first go through, so I don't know that I got into the details of the evidence review, but the developers have provided quite a lot of really great resources that I'm sure on repeated reviews will be helpful to digest even deeper.

As you mentioned, it is a composite measure that really looks at a process and a set of processes related to whether or not a patient who has been identified as having asthma in a ED visit or hospitalization for asthma had some kind of connection to primary care prior to that ER visit. And the definition for the connection is composite of three items.
So first is what their visit to a primary care clinician and the six months prior to that – your hospital visit. Second is in the 12 months prior to that, was there a fill of a short acting beta agonist? And third was six months prior, was there a controller medication prescribed and filled.

So a couple of quick take a ways from that for me was, first of all, is that title (inaudible) the proportion of ER visits for asthma and primary care connections before the ER visit, but I think the measure itself is a little bit more broad than that since it's also looking at hospitalizations. And then a couple of other quick observations that I had was that the measure focuses on primary care clinicians as if – and I wasn't sure yet, whether or not that would exclude from the measure, patients whose asthma was being managed by an allergist or a pulmonologist. And that was more of a question that I have actually than a statement, but that was an observation I had by looking at the composite.

And then another piece of it is that these are patients who to meet the composite measure would also need to have a controller medication, so it seems most pertinent for kids who have persistent asthma.

The developers have used, I think, in addition to this composite measure, an approach that – I'm not sure that this is correct, but it might be novel for this measure for defining kids who have identifiable asthma. And that was another question I had is whether or not that definition of kids in the denominator group who have identifiable asthma based on some existing work

– they referenced the differences between how HEDIS describes (this) was persistent asthma, but the definition used here is a little bit different. And so the evidence review is focused a bit on ER visits for asthma and the effects that high quality primary care could have on care visits.

And I think one of the discussion points for the group is the extent to which the evidence provides really pointed and precise information for the items in the composite measure versus high quality primary care and the ER visits. So I think a lot of the evidence is focused on a few concepts, some of which are embodied within the measure having certain visits and certain medications prescribed and filled. But then certain components of the evidence review is focused on things like asthma action plans and communication, which isn't particularly addressed (inaudible) within the measure itself.

Looks like sort of the pre-populated evidence algorithm conclusion rating was – the check box was filled in for high. Systematic review on the topic, I think a lot of the evidence summary comes from the EPR-3 guidelines, which I don't know if we'd meet the criteria for a systematic review for this purpose. So I wasn't sure if – in the absence of a systematic review, if I understand that correctly, if the evidence – you would sort of by – the algorithm would by default actually make it at best moderate. So that was another question, observation I had. Maybe I'll just take a pause there because I've said a lot.

Margaret "Peg" Terry: Yes, thank you. Let me just tell you because you probably may not know this, that what you see here now in the algorithm was really what the staff did here at NQF. It's what we call preliminary analysis and it is just that, it is just our opinion, but the committee cannot, does not have to have that same opinion. So I'm just letting you know, I don't know if you knew that.

(Ryan Collor): Thank you.

Margaret "Peg" Terry: And what the staff here did is they pulled the information that you see on this, the preliminary analysis from information that came in from the developer.

So are there any questions? You, really, you hit on all the important points really well. Anybody have any questions or Gerri?

Gerri Lamb: Just a few comments and then certainly questions and first off, (Ryan), great job and thanks for jumping into the fray. This is a more complicated measure so I just – Peg, if it's OK, let me just provide a little bit of context here.

Margaret "Peg" Terry: Perfect.

Gerri Lamb: When we get together, we are going to be looking at a combination of maintenance measures that have been through review before and new measures. This is a new measure, it's a process measure and it's a composite, so it's a bit more complicated than some of the others we're going to be reviewing.

The other thing to know is, at least from my vantage point, OK, many of the measures that we've seen in the past in this committee, for those of you who are new, really are kind of starter measures. Really getting us into the domain of Care Coordination, but there's been issues with them. You know such as measures that look at did you make an appointment? And that becomes kind of the gap area in terms of so was the appointment kept? What happened at the appointment and so forth?

This measure is a new one and as a composite, it's beginning to move the needle, at lease in my view, towards the greater complexity of Care Coordination and I think (Ryan) did a great job in pointing the three parts of the component. So when we're looking at evidence, we discussed this yesterday as well, is that it's evidence related to each of the component parts and so the measure developers provided – and (Ryan's) question is an important one. Is the systematic review based on guidelines that addressed each part of that component, so whether it's moderate or high as Peg was saying, the high rating is the National Quality Forum's staff call. We can rate it the way that we evaluate this so that I'm going also – for the face-to-face meeting, encourage everybody to go beyond the NQF review and go back into the documentation. Particularly if you are a designated primary or secondary reviewer, although all of us will be reviewing all of the materials.

So I just wanted to share that so when we look at evidence, it needs to be specific to that this is a new measure, it's a composite measure and there needs to be evidence as (Ryan) said, related to each component.

Peg, (Ryan) raised some questions, I'm wondering if – I believe we have the measure developer on, is whether as we look at the measurement specs, whether a pulmonologist is considered a provider in this case and any comments about the diagnosis of the asthma and how that's established. And I think the systematic review question is more one for you, Peg.

Margaret "Peg" Terry: So (Suzanne)?

(Suzanne Lowe): Hi, this is (Suzanne), I'm kind of just taking notes at this point for Dr. (Climan), I don't – I wouldn't feel comfortable right now answering for him, but I will pose these questions to him and have him respond. Unfortunately, he isn't able to be on this call today.

Margaret "Peg" Terry: OK, so it's something I think to keep in mind to find out whether it's just a primary care practitioner or if it's in – or it can extend to specialists such as a pulmonologists. And the – what is the identifying asthma, what is that particularly, the definition of that? And as to whether this is systematic review, this is – what we did here at NQF is we actually looked deep into a document and we had you know information on it and the document is a National Asthma Education Prevention Program which really provided most of the graded evidence.

The evidence was graded and we accepted that. It wasn't – didn't – the systematic preview means that wasn't it wasn't systematically done and we did not have that level of detail provided to us. Although it may be there, we did not have it provided to us.

Barbara Gage: This is Barbara Gage and I have a question, speaking more to methods issues and having no clinical background. The three measures that are, the three components that have been identified from the field of asthma care, is there – I guess my question as a methodologist is, why were the two medications that were selected for bullet two and three selected and my thinking is, my concern

is that it may be excluding other key treatment factors that would also be important in identifying the universe of these patients.

Margaret "Peg" Terry: Yes.

Barbara Gage: But that's just a question. Is that – are these comprehensive enough to identify all of the appropriate patients? It's kind of similar to the question that was just raised about kind of pulmonologists being counted as a primary care. You know many of these children may be going to a pulmonologist because of the existing asthma and it would be a gross undercount to only have an internist or somebody as the PCP.

Similarly, I concerned that the two drug types, the beta agonists and the asthma controller medication may be inadequate for identifying the whole range and that could introduce a bias that we only have select types of cases.

Margaret "Peg" Terry: So that's kind of a question for the developer, but I don't know if any of the physicians on this call who may be familiar with asthma can at least give us some insight into it?

(Ryan Collor): This is (Ryan), I'm a pediatrician, I can – so I think the question which is related to that, but about a slightly different aspect of the measure, more related to I think (denominator) is the measure attempts to identify kids with asthma actually using a bit more complicated algorithm, which is I think deeper into the document. And that's where I had some questions I guess for the developer about – to what extent that's an established approach. And it's compared and referenced to HEDIS, but I'm not sure if it's novel for this measure and their use or if it's been sort of established in other settings.

As far as the numerator for the measure with those three items, the visit to the PCP, prior to the ED visit, filling a short-acting beta agonist and filling a controller med. Prior to an ER visit, I guess I think we depend a little bit on the evidence review to figure out whether we think that that's going to under count or over count kids, I don't know that I have a good conclusion on that yet. And probably need to go back a little bit more deeply into the evidence review that was provided.

But I do have a related question that which is the denominator statement is that it's all first ER visits or hospitalizations in which asthma was the primary or secondary diagnosis and clinically speaking, if I'm understanding that right, a patient who's got a first ER visit or hospitalization for asthma may not actually, clinically need a controller medicine prior to that visit because this is – the numerator then looks back at the six months prior to that visit.

So I may just be misunderstanding the language but I guess I share a kind of a related question about (greater) as in a composite items as listed and whether there's any clinical disconnect there or not.

Richard Antonelli: This is Rich Antonelli, (Ryan), I also want to pause for a moment to congratulate you for doing so well on your debut on our committee, thank you very much and congratulations.

The point that I wanted to raise as well, I'm struggling with the lower limit of eligibility of this two-year old and in my clinician mind. I'm trying to make the case for why the developer would give a six-month window. You know I can imagine at the other end of the age spectrum, so say it's an adolescent who's got an established diagnosis of reactive air ways, AKA asthma, one could argue that you would review the asthma control test score and the asthma action plan even at an annual visit, much less as inter-occurrence of acute sick visit.

But on the lower end of the age spectrum, I'm struggling a little bit with what giving a window of six months prior to that index ED visit. Does that make a lot of sense, is there clinical logic attached to that? Is the person taking notes for the developer able to address that or can the – we just revisit that when you guys are ready?

Female: I think it's probably best to revisit that when you guys can answer that. Thanks.

Richard Antonelli: OK.

Margaret "Peg" Terry: I do believe that (Larry) and (inaudible), I'm so sorry will be able to address that, who is a physician who is one of the developers.

Gerri Lamb: Can I also ask, are – is NQF staff keeping a list of all these so that we can go through them when we get together because I'm hearing questions about the population, about the measure specs, about the evidence that I think would be helpful if we just had a list and the measure developer can, kind of, walk us through the questions?

Margaret "Peg" Terry: Yes, we are. We're taking notes here.

Gerri Lamb: Perfect. Thank you.

Margaret "Peg" Terry: And this is also recorded, I must tell you that. Which, we will view.

OK, so any other questions on basic evidence? So, the next section is really what we call opportunity gap and care opportunity for improvement. And you know, this is – this is important for us to really have a sense of whether, based on some of the data that we have, whether the committee thinks that this is – offers that.

And so, do you want to go through that, (Ryan) or somebody else? So, this is just – this is really just a second part of the evidence section. And again, this is primarily the data that's here is Medicaid data in New York State, we'll say that. Did somebody want to just take a look at this and, sort of, comment on it?

(Ryan Collor): This is (Ryan). I'll just make one comment that crossed my mind. I think, and I think it actually comes up later in the document, the disparities that appear to be most present in the – and, I guess, the synopsis here is really related to disparities in the outcome of having ER visits or hospitalizations. That seems to be the most specific highlighted disparity, but I think that the gap would more in a process of having controller med and the Albuterol in the clinic visit. So, I don't know, I think it's there actually in other places in the document. I think, I saw some info related to differences in different sub populations in performance of having a controller med for example, having primary care visits, but it just come across to me quite as much in this section.

Margaret "Peg" Terry: OK.

(Ryan Collor): Anecdotally, I …

(Off-Mic)

Ellen Schultz: This is Ellen Schultz and I had, very much, the same thought in looking at this. Something else that I would like to have the developers clarify, if not today then certainly when we review this later this month, is that I noticed in looking both at this measure so this is 3170. And then, also looking at the related measure 3171, which is about you have an ED visit and then what happens afterwards, it's about follow up.

Under this performance gap section, exactly the same statistic is cited. The developers state that 16.5 percent of children in New York State Medicaid had a qualifying ED visit for asthma and matched the standards for this measure. I find it hard to believe that it was exactly the same, 16.5 percent that had a ED visit and like met the standards for the measures looking back and looking forward.

But because that's a really precise number. So, I just wonder if perhaps there's a copy paste error or something there. In which case, then I don't know, really, what to think about what the current level of performance is for New York State Medicaid. So, it's a little hard to judge, like, what is the actual gap or the room for improvement.

Margaret "Peg" Terry: And we're taking notes on that as well and I'm sure (Suzanne) is. Any other questions on this area of gap?

Richard Antonelli: This is Rich Antonelli, so there's something called a Community Asthma Initiative, which is the – basically it's a home-based intervention for asthma. It seems to work very well for urban population. And so, in thinking about this measure as potentially filling a gap, is there – I'd like to know is there any comparative data for commercial populations tat was used to look at improvement opportunities, that might give us the ability, in fact, to test the connection between access to primary care, especially with such a long window of six months and ED utilization for this composite.

And the reason I brought it up, the Community Asthma Initiative is because this measure has a specifically a primary care visit, I don't know that a home visit would necessarily meet the measure for the composite.

Margaret "Peg" Terry: That's a good point.

(Jeff Wevricks): Hi, this is (Jeff Wevricks). One comment on the gaps. The information provided talks about a qualifying ED visit, but in the description on the measure it also talks about a first hospitalization. There's nothing mentioned about any of the first hospitalization or if anybody qualified from that standpoint either.

Margaret "Peg" Terry: So, where you're reading on the numerator or denominator statement? I'm just trying to understand where you saw that.

(Jeff Wevricks): The denominator statement, "All first ED visits and/or hospitalizations."

Margaret "Peg" Terry: I think it's – I think that they have both of them that they're looking at. Is that correct, (Suzanne)?

(Suzanne Lowe): I'm trying to figure out where it is.

Margaret "Peg" Terry: So, the denominator is not just an ED visit. It's also ED and/or hospitalizations. Is that correct?

(Suzanne Lowe): Yes. I believe so. Any hospitalization with asthma as primary or secondary diagnosis, or one of the other qualifying events.

Margaret "Peg" Terry: I don't know if that answered your question, but we are – we're writing it down so we can bring this forward.

(Jeff Wevricks): I just was wondering, because it states under the performance gaps section and just talks about 16.5 percent of the children who had qualifying ED visit. I was just curious if that also included a qualifying first hospitalization visit.

Margaret "Peg" Terry: That's a good point. So, we have – we're noting that. Thank you. Any other questions there on disparities or gaps?

OK, so the next section is, what we call the 1C section, their evidence. And it's really about construct. And this is, you know, this is what we do for all of these composite measures and, you know, basically you can read what we have here. The quality construct or rationale should be explicitly articulated.

Logical and – I'm trying to find the wording here – can you put it up please, down, down, down, right, right down here, sorry. Can you put that over? Yes, should be explicitly articulated and logical. A description of how the aggregation and weighting of the components is consistent in the quality construct and rationale, so should be explicitly articulated and logical.

So here we have the three components. And we have basically what developer said about this and this is what we call an all or none composite measure which means all factors or all components have to be there. Does anybody want to comment on this?

Ellen Schultz: This is Ellen. So I also wondered a little bit about the all or none approach, that's sets a pretty high bar and in particular some of the questions about – for example, well what if asthma is being managed by an allergist and not a pediatrician or primary care. What if patients had a home visit about asthma part of special program so that's not captured. Taking an all or none approach really sort of forces you to worry about some of those details. Taking a little different approach where there are a couple of different ways to satisfy the numerator might help with that.

So if my child's asthma is managed by an allergist, but he has both a controller medication and a rescue inhaler then that's another way maybe to meet the numerator through the medications and it doesn't matter who prescribed it. And so particularly controller medications, I would think, would be prescribed by someone who's sort of managing ongoing care.

And so I wonder that whoever it is that's writing that prescription might be fulfilling that requirement because it might be something for consideration.

We have a chance to hear from Dr. (Climan), I'll be interested to hear sort of what the rationale was of setting the bar so high.

Later on in the packet, they had some information that sort of broke out, stratified results. So the percent of cases that met just criterion A and just criterion B and just C and then the different combinations of those. In many respects, I found that to be more helpful information and so I guess a question to our committee is, if the measure is designed to be all or none, but then there are specifications for this more detailed stratification in a reporting, is that enough that we feel like it sort of offsets any concerns around an all or none approach.

Shari Erickson: This is Shari and I have similar question in maybe a different way and I – get to some of the last part of this packet for this measure specifically but you know when you talk about primary care, at least in internal medicine which I know has many similarities obviously, the theatrics in terms of the physicians that are engaged in providing that type of care. I mean, you have internists are all trained in general internal medicine before they sub-specialize, and I believe it's pretty similar for the pediatrician.

And so sometimes, when we've talked about defining primary care, it's around the services, which can be defined through some – look at the actual code. And I know that that's part of this too, but, how – is it the services, is it the individual, is it a combination thereof? Because that gets many physicians that are treating a lot of patients for asthma may be providing predominance of primary care, perhaps, for that child and so they would sort of fit the bill anyway, even though they're sub-specialized.

So, I guess – and part of it may be that I need to get though some of the last bit of this to understand with clarity exactly how they've defined the primary care, use the term services, actually, under the description of the measure, but then when you get to this piece where we are now, it's using the term practitioner, and those are different.

Margaret "Peg" Terry: OK. So, any other comments on this since – we could – it's just a thought, we could go to the section under validity that you can see – what we

call the construction of the composite with some of the way there has been compliance by different parts of the measure. Now, if you think that would be helpful, or we can just continue here. Any thoughts? Ellen or Gerri?

Gerri Lamb: You know, I'm thinking that the process – just since because we're going to review, Peg, might be good to wait on that. We do have, I think, a question that's been raised now, consistently, is not only the three components of the measure but the bar being too high.

And I'm also thinking, yesterday we were raising points, in terms, of measurement gaps and Care Coordination and this just revisits the whole idea of conditions, specific measures and the specificity that's required for them. So, there's pieces and parts that we've got all over the place.

So, my suggestion, long story short, is let's just keep going though and hold it, we do know that there are issues that – and questions being raised about the composites.

Margaret "Peg" Terry: OK. That sounds good. Thank you.

So, the next area that we want to look at is reliability. And so, this is a composite measure and going to – I just want to start with this. And according to NQF guidelines, you can only evaluate the measure based on the measure score, you can't do it based on any data element evaluation, which we looked at a bit yesterday. So, I did want to start with that, so you understand what we have here. And when it's based on measure scores, the comparison of two entities, it could be a county, a state, or a population, whatever, where you would have different level of testing, different kind of testing, that element is usually the elements of how the data is obtained and it's usually – one way to do it is interrater reliability.

So, this reliability must be at the measure score level. I just wanted to start with that. So, would somebody, please, be willing to go through the specs and go willing – willing to go through reliability here?

Barbara Gage: Hey, this is Barb. I'll jump in here.

Margaret “Peg” Terry: Thank you.

Barbara Gage: The point that you just made about the composite measure being tested for reliability, if that's a requirement, then this composite measure does not meet that demand. The tests were done at the date element level. Very common, very respectable, but, not at the composite level, or at least, no results were provided. So can I ask a question? So, as a – as a review committee, that's suggests that this measure does not meet the reliability standards that are need, is that true? Am I interpreting that right?

Margaret “Peg” Terry: And so, just so you know, there's an algorithm that we did, and we have seen in some the work that was turned in by the developer that they may be some data available, but we have not seen it. Comparing counties, maybe other data as well.

Barbara Gage: OK. And the other notable thing is, that these were plain data, so claims – well, I was going to say are often more reliable that survey data or other more subjective elements, but that said there are also errors in claims data, so never mind.

Ellen Schultz: Well, so, this is Ellen. These aren't specifically ambulatory care claims data for the most part, so, denominator looking at ED visits or hospitalization are inpatient, but the CPT codes for example, are around primary care visits or services. Those are ambulatory and based on my understanding, ambulatory claims data are not viewed with anymore near as much confidence in their accuracy or reliability as inpatient claims, because they're not audited.

I also had questions about the data used to confirm that prescription was filled. So, I'm just curious, what would be the data source, so a typical claims file that you would bet from a hospital or an ED, for example, would not have that data. Now, I understand that, some of the testing that was done was for Medicaid, so it may be that that – the prescription filled information is included within the Medicaid file. So, it would be good to understand a little bit more from the developers, how that comes into play. And I am wondering, would that be a limitation in implying – applying this measure to others so it's a population if prescription fill data is not really available.

So, for example, if you wanted to look at the population for a county, what if you only have fill data consistently for Medicaid enrollees? I would see that as a problem. I know that there are a number of all payer claims databases that are available in certain states, and so, maybe that would be addressed or partially addressed in some places but not all, so, I am just interested to hear from the developers, what are limitations are a consideration based on the data source? And especially, around the prescription fill data.

Margaret "Peg" Terry: OK. Lots waiting to hear from the developer. A lot of questions, and I think that is great.

Gerri Lamb: Peg, the other thing similar to the discussion yesterday, is – is that the reliabilities results are for reliability testing is – is, as I understand, is required, so if we do not have these data for the review, we're not going to be able to move this forward. Is that correct?

Margaret "Peg" Terry: That's correct. This is a must have.

Gerri Lamb: So, I think the developer really needs to have that information so that we can not only get our questions answered, but this one would be one that we can't move forward.

Margaret "Peg" Terry: OK. Any other questions? If not, I'll move onto validity.

So, here, the way validity is done, and it's acceptable with NQF standards, and I'll just touch on that briefly, is that we actually can used research data, articles with research data that basically provides testing data that we can use prior – this prior information using basically on data elements.

So, what I though we would do is, and what we did is asked the developer to provide this, to us, and they did. And they did it and we actually were able to provide some of this. So, that's how – that's how validity was done, it was not done on specific testing. But it was done based on some prior studies that were done.

So, with that said, Barb, do you want to comment on this at all?

Barbara Gage: I'm sorry, did you say Barb?

Margaret “Peg” Terry: Yes, I did. Sorry.

Barbara Gage: Yes. I have to admit, I was looking back at the evidence file as you were talking. Could you, I'm sorry, could you please repeat the question?

Margaret “Peg” Terry: So, I just asked if you wanted to – I talked about how we looked at validity here and basically how we – how NQF staff was able to do some level of evaluation here, and we did it based on prior studies and this is what is presented here and that's acceptable for NQF.

Barbara Gage: Yes. And as they – from claims-based are pretty are pretty standard in terms of validity. Again, I don't know the asthma field, but, they – if you're using commonly accepted codes, in that field, that's a good statement of validity. And it looked like that was what they were supporting, in terms of the evidence they presented.

So, the validity, I thought looked OK. But, again, not being a clinician, I don't know if there's some type of – if they were referring to – I mean it certainly looks like the right literature. Asthma diagnosis and the different settings and the – if you look at the threats to validity, the 2B3 proposed exclusions, they identify certain categories to exclude and I don't have the clinical background to comment on whether that was appropriate or whether, in fact, in considering validity, the results associated with those populations with COPD and emphysema and what not, should've also been included. But it looks like they did their homework.

You know, as you look through the evidence, they're certainly looking at the articles that they identify. They're looking for markers of related issues, accepted markers and at, that those, you know, that they're documenting that they were significant in the work that they looked at, which suggests that that the validity is there.

I don't feel very articulate today. Was that clear enough?

(Suzanne Lowe): Well, this is, this is (Suzanne Lowe). I know from several discussions with Dr. (Climan) that he also felt that claims data was pretty well defined in the field, as being valid and reliable and it's been proven throughout the literature in a number of diagnoses, and especially even in asthma. I know he felt strongly that it was, already been vetted to be pretty valid way of defining things.

And also, I was looking back at some of the notes. Someone had brought up the idea of the home-based visiting, and that is sort of the code (set) for counting as a primary care visit home services and their codes. I just wanted to …

Richard Antonelli: Could you, could you get a little closer to the microphone? I'm losing you, please.

(Suzanne Lowe): Oh, I'm sorry. I was just saying that what she was, Barb, was saying about the claims data – can you hear me better now?

Richard Antonelli: Much better, thank you. In fact, if you could repeat the whole sentence, that would be helpful.

(Suzanne Lowe): OK. So, I know in several conversations with Dr. (Climan) that I know he felt strongly that claims data was pretty valid within asthma work, as well as other diagnoses. And that that looking and basing things on claims data was proven valid from a while back ago. So, I know he felt strongly about that.

But I know someone had mentioned earlier about the home-based visiting, and whether in the Community Asthma Initiative, and whether that would count, and I know – I was looking back at some of the data, and it shows that primary care visits do include home services codes, and so that would be inclusive. So, I just wanted to put that out there.

Margaret "Peg" Terry: Thank you, (Suzanne). So, is there any other questions on validity? OK.

Gerri Lamb: Peg, this is Gerri, just one thing to point out for folks. You know, if you're like me, trying to kind of follow the algorithm, especially for this is the gold

standard review, not the typical one. One thing I found real helpful, once it dawned on me that's what it was, is in the green boxes. It takes you through the algorithm, and it takes you through what points are yeses and nos on the algorithm, in case you want to follow that.

And so, that's true for both reliability and validity, and I …

(Off-Mic)

Margaret "Peg" Terry: Gerri?

Gerri Lamb: Yes. Are you still there? OK.

Margaret "Peg" Terry: Thank you for pointing that out. So, if there are no other questions, why don't we move on to the, a little bit more detail on the composite measure, and some of the empirical analysis here, and how the, the sort of stratification of these parts to it, per se. And I'd like to see if somebody else could, could talk about that – look at these percentages, it's really speaks to the, the way the composite was set up in some of the testing or data that they have to date.

Ellen Schultz: This is Ellen. I didn't get to review this measure in as much detail as I did for the other measure that I was assigned to, but I'm willing to take this on since I raised the point related to this earlier.

Margaret "Peg" Terry: Thank you.

Ellen Schultz: So, they, so in this section, they do provide some data that sort of breaks down by each element within the numerator, and so, the first element about having some sort of primary care visit or services within six months before the ED visit or hospitalization. It looks like about 28 percent of their test sample had such a visit.

Looking just at that alone, you know, to me that shows a good deal of room for improvement. Looking at the second element, which is having at least one fill of a short-acting beta agonist within 12 months before the index, ED visit, or hospitalization. About 3/4, or 72 percent had a fill like that, so there's little

less room for improvement there, but still enough of a gap that it seems reasonable.

And then for the third element of having an asthma controller medication filled within six months before the ED visit or hospitalization, it was about a quarter, 25 percent, had this filled. So, clearly each of the elements has room for improvement, and then, as they had stated in a separate section, it seems like when you put all those three together, there's really only about 15 percent of the denominator cases that actually managed to meet all three of those criteria.

And then they provide some additional information, sort of, in combining the numerator elements in different ways. So, you can see some of the variation that ranges between like 64 percent that don't – they don't have a primary care visit and they have only one of the two medications. I think, if I'm interpreting that correctly – all the way down to about 18 percent of denominator cases that didn't have either of the two medications.

So there is some risk information here and, as I said previously, personally I find that helpful in thinking about interpretation of this indicator. And it's something I think (as) a strength of this measure; that if you can stratify it out in these different ways, it can't really get to the more actionable information.

Just think about where are the gaps. Is it in getting primary care services or is it in filling medications? Is it around the short acting versus the long acting inhalers? So I really like the fact that it is possible to break out pieces and look at them individually as well as the composite piece.

Margaret "Peg" Terry: So thank you, that was really excellent. Anybody have any questions? Or comments or thoughts?

Lorna Lynn: So this is Lorna Lynn. I apologize if this was covered earlier and I missed it, but I'm asking this in part as the parent of two kids with asthma. I'm a little – I could speculate, but I'd like to hear from the developer why the time period was six months for the asthma controller and 12 months for the short term – for the short acting beta agonist. Just thinking about how prescriptions get filled and how the use of the medications can vary with seasonality and colds

and things like that. So I'm just interested in the rationale for the 12 months and 6 months.

Margaret "Peg" Terry: (Suzanne), do you want to comment on that at all?

(Suzanne Lowe): For that one – I'll probably leave that one to (Larry) because this work has been previously to me joining the team.

Margaret "Peg" Terry: OK. And I don't know if you were on earlier, but we don't have one of the developers on this call.

Lorna Lynn: Yes, yes.

Margaret "Peg" Terry: OK. Thanks. All right, so we are taking copious notes here. So – and I'm sure (Suzanne) is as well. So thank you, good comment.

Any other thoughts, any other comments, questions? OK. So feasibility; as you all know, feasibility is really about whether you can actually obtain the data easily enough, whether it's accessible. Anybody want to talk about this here?

Barbara Gage: This is Barb, I'll take it on. Using claims – assuming that the specifications are the right specifications, these are readily available through claims systems. So that should make it very feasible.

Margaret "Peg" Terry: Yes. OK, any other comments on that? Questions?

Gerri Lamb: Just a reminder that we had an earlier question about pharmacy capture. So when we have the measure developer with us, we can ask that one.

Margaret "Peg" Terry: Thank you. And then the last criteria is really usability. And so this measure is not in use. And does anybody want to make any statements about it here?

Ellen Schultz: This is Ellen, I mostly just had a question or a comment that – there are a couple places throughout the application that there was mention of an analysis at a health plan level. But then the actual sort of what was put in the official

form check back to was that this was meant to be sort of a population level at a county or a state.

So I wasn't totally clear whether they're intending endorsement just at the population level or hoping to have it for both, we – obviously, we need to see some data at a health plan level and looking at the ability to detect meaningful differences and reliability based on health plan data if that's of interest.

But just thinking about the use of the – certainly I could see a lot of value to health plans or ACOs; organizations that are really trying to do population health management. And that's a strong argument for me in support of this measure. It'd just be nice to have a little bit more clarity in terms of how it's intended to be used.

Margaret "Peg" Terry: And (Suzanne), again, I keep going back to you. Do you have any information or any knowledge or any thinking about that?

(Suzanne Lowe): Well, I know this was – the data is actually owned by New York State, so we've been working closely with them for analysis. And it was done at the population level across the state and I believe Dr. (Climan) also saw such like great value in doing it at the health plan level, but I am not certain and I would have to check with him if we have actual data on the health plan level. But the intention is that it could be done for population health management is a great tool for using this measure.

Margaret "Peg" Terry: OK. Well thank you. So Gerri, do you have any comments on this and anybody have any other questions overall on the measure? I want to thank everybody for jumping in and helping us walk through this measure. Looking at the criteria, great questions and yes, great questions so – Gerri, do you want to follow up with anything?

Gerri Lamb: Sure, sure. The intent here was for us to use one of the measures we're going to be going through in great detail in a couple weeks to get a feel for the process and like Peg is saying, thank you all for just jumping into the fray. This is really the way it needs to happen and having the measure developer there, in a couple weeks, will be really useful to us. We wanted to use this one as a prototype for a couple of reasons for the review. It's a new measure,

as we said, and as a composite, it's a bit more complicated, the algorithms are a bit more complicated.

We do have a measure that goes along with this – this is the post hospital. We also have 326 which is the advanced care plan which is a maintenance measure. So the review for those or for the maintenance measure is going to be a little bit different.

So Peg, it looks like we have enough time. If any of you have questions about 326, the advanced care plan, because my expectation is some of the questions related to the companion measure for the one we just review are going to be somewhat similar. But 326 is maintenance – we do have the measure developers from NCQA with us so if you have any questions for – about this measure so that we can anticipate the discussion in a couple of weeks plus to have NCQA on is a real boon right now.

So those of you who took a look at 326, do you have any specific measure questions related to the review? We're not going to go through each of the same steps that Peg did, unless it's obvious that we need to do that. But if you have specific questions that we can put on the table and anticipate, that would be very helpful.

Ellen Schultz: This is Ellen, I have one point I just wanted to clarify around the source of the CPT code that are used in the specifications for this. So EHR is listed as the source in various cases throughout the application, but it was not clear to me whether the EHR is just the source of where the CPT codes would get pulled from, or if there are other data elements embedded – typically embedded within EHRs that are required for this measure?

Bob Rehm: So none of us who are at NCQA – and by the way, Mary Barton, who's our Vice President of Performance Measurement, just joined us by phone. But none of us where here when that measure was developed back in the day. You're referencing that the measure was tested in EHRs which was a very feasible and I will say an approach that AMA PCPI that co-developed that measure with us, again, sometime ago used.

And so the CPT II codes which characterize the quality actions that are defined in the EHRs, so they were looking for those things, they weren't looking for those CPT codes, the CPT II codes are the – officially the literal action that were represented by, either people identifying a surrogate or being approached by the provider around advanced care planning and/or either saying, I'm interested in doing that or I don't want to talk about that with you. And all of those are the elements for the numerator.

So the CPT II is a convention created really for the – to be used by the PCORI back – again, going back in time and then also then carried over into the PQRS program as well, so there is no corollary ECQM or Electron Clinic Quality Measure for this – for this particular measure that you're seeing here.

Ellen Schultz: OK. Thank you.

Bob Rehm: I don't know if that's helpful or not. I know that's a little bit of a tortured past, but.

Ellen Schultz: But wait – so I think where I was going with that question is that some of the testing that was done around the data sources and feasibility was from 2009. And we all know the EHR landscape has changed dramatically in the last several years, so I was wondering if there were EHR elements that really were critical to this, whether there might be a need for updated testing, but it sounds like if it's really the CPT codes that are the important element and unless those have undergone major changes in the intervening five or six years …

Bob Rehm: Right.

Ellen Schultz: … then I wouldn't expect that the …

(Crosstalk)

Bob Rehm: Yes, for maintenance measure, you know, right. So again this measure's not – we're not requesting this to be approved as an electronic clinical quality measure, an e-measure or, it goes by lots of designations. NQF has its own criteria for that, we're not on that path and I …

Ellen Schultz: OK.

Bob Rehm: So I think that you're right. We've done some other work under other grants and contracts and other work that we've done here at NCQA that inform us that the fields that could capture advanced care planning are still not consistent, but there's more there than there was back in 2008 and depend on the test site you happen to choose.

If you chose one where advanced care planning was important, guess what you found? Fields that captured that, so I think there's broader and broader recognition that this is an important area of care and just one component of care planning.

Ellen Schultz: Thank you. Just a quick question related to the CPT codes and I don't – I can't get to the link right now. Is it inclusive of the most recently approved CPT code for payment by Medicare for advanced care planning?

Bob Rehm: That would qualify for that – again, this is a programmatic requirement but we will look for that and …

Ellen Schultz: Medicare just started paying for that.

Bob Rehm: Yes. This measure was the – this is the measure tied and while it's universal it is – its area of us in – for physician accountability is in that particular program which has its own particular time frame and time table for updates. Those updates were consecrated back in, like, September last year.

Ellen Schultz: Yes. Well – yes.

Bob Rehm: Yes. But that's something, in terms of updates, we are allowed once a year, to update those measures and we can look into that. In fact this is the perfect period to do so. And we would normally run the – our team would run through that probably in March or April and I – because we're aware of that coding we would see if it would be fruitful for the measure.

But right now, if they did have that code – these codes would – people who would code these codes (inaudible) practice, because they met the intent.

Ellen Schultz: OK. All right, thank you.

Bob Rehm: You're welcome.

Margaret "Peg" Terry: Any other questions? That was a great one. I had the similar one and while you're thinking of questions, I noticed in the materials that were provided, that this measure is currently being used in PQRS, any plans for using it in other programs – or any discussion?

Bob Rehm: Well actually, as many of the PQRS measures have, but certainly not all, it's also included in the MIPS program, the upcoming program. So if you go to MIPS site that has the quality payment program, I guess is their new – their new kind of branding. So it's QPP, you will see 0326 is in that program as well.

Margaret "Peg" Terry: Thank you. Other questions from committee members?

Lorna Lynn: Yes, I had one, this Lorna Lynn again and I'm almost embarrassed to ask this, but it wasn't entirely clear to me from reading the measure, what is the reporting period that you're looking at here?

Bob Rehm: It's annually.

Ellen Schultz: Yes, I think I had a similar question about that Lorna, because I was wondering – would you really expect advanced care planning to be updated annually, so …

Lorna Lynn: Yes.

Ellen Schultz: It be the case that someone did their care planning and so it doesn't need to be revisited, would that then count against an entity.

Bob Rehm: Yes. So let me – let me …

Ellen Schultz: Or is there a way to pass through …

(Crosstalk)

Ellen Schultz: … a plan that exists.

Bob Rehm: Right. Let me rephrase. The program is an annual program so if I had – and I think I've captured this correctly and I'm looking to my team to back me up. If I – let's pretend it's December and I had advanced care plan documented. I do not have to have an advanced care plan re-documented in January next year and then in the following January.

I think that we would look for evidence that there's been that discussion, it's been held and it's documented in the record. And so the decision is reporting on that measure – that I believe is evidence of that. But we're checking on the specifics of those.

Lorna Lynn: So is that a discussion ever taking place or taking place annually? It's kind of tricky because – I'm not sure you want to do this annually, on the other hand, I'm not sure you want to do it 10 years ago and assume nothing has changed.

Bob Rehm: Yes. So looking at the performance of the measure, the reason why I'm hesitating here, and I apologize, is that we happen to have a corollary measure that looks at how this is done in special needs plans that NCQA has, this is not the measure that you're seeing here, but it's a similar thing and that is an annual assessment, but then people with special needs plans have special needs and are particularly critical.

So this is the – the measurement year for the measure, for the program, is annually, which is the reason I responded that way. I don't believe, in looking at the rates of performance, which have gone up fairly steadily, and the population of providers that report the measure. I believe that this is a – you're looking back in the medical records to see if that occurred. And it could be – and I apologize that – we'll have a much better answer for you when we get together – that the provider is saying, "Gee, last year or two years ago, when you last came in we talked about your advanced care planning and you said this is your surrogate and this is your desire, or you didn't want to talk about it. You know, is this up to date? Does this continue to express your wishes?"

And I believe that that is certainly the intent of the measure. I think that's how actually it works, but we'll be able to provide a better answer for you.

Lorna Lynn: Thank you.

Margaret "Peg" Terry: Any other questions or any other comments on this measure? I think these are great questions and it really helps us – helps everybody sort of begin to think about the measure and basically – the developer to help us with some of the answers.

Ellen Schultz: This is Ellen, I just had one other comment and question. So, under disparities, the developers note that there's no stratification of the measure by patient groups or cohorts that could be affected by disparities through NCQA. I do wonder that, like, having a regular doctor or access to primary care or everyone is defined, sort of the notion that patients actually have someone that they go to regularly for healthcare.

It seems to me that that could very much vary and that could be tied to disparities. But I don't know if that's something that's been explored. I don't know if that's something where there's data, that it's possible to explore that. But it might be something to consider because I – you know, we all know that there are strong disparities in terms of access to care and having a primary care provider. And that if you don't have that continuity of care and a relationship with someone, I would think you'd be much less likely to have an advanced care plan.

Bob Rehm: Yes, I think that having a source of usual care is – obviously is the goal here. Yes, I think that that's a really good point that you made. The PQRS program, which is where, you know, we have data that it's reported on, you know, physician level, and it's those who choose to use that measure to report – they have to pick several measures and then the new quality reporting program that CMS is just starting up is – has different programmatic requirements.

It could very well be just from a disparities point of view that they're able to report on other areas, such as race, ethnicity, and maybe some other components. But I think whether or not the patient has a usual source of care

is not been one that I've heard of, but I think it's – I think it's something that we and others should explore.

Ellen Schultz: Thank you, food for thought. I know that NQF is really trying to give a lot of additional thought to …

Bob Rehm: I think the whole world is trying to figure this one out.

Ellen Schultz: Agreed.

Margaret "Peg" Terry: So, any other questions or thoughts on this measure, or on the measure we didn't discuss, 3171?

Richard Antonelli: So, this is Rich Antonelli. If I could just mention something, and it isn't necessarily even specific to this measure, but to maybe give some guidance to both this group and then for conversations that happen later on, say at the MAP or steering committee. And that's the following, we – it actually builds off the first question. So this is not an EMR measure and is very clear – and, in fact, I want to thank the NCQA person for the very clear answers, but is it in scope for our standing committee to know from the NQF staff about potential measures that are in or may be coming to NQF that say would be e-measures?

And the reason I'm asking about – just thinking about issues of parsimony going forward. Again, not specific to this; it's been MIPS and the other things that are there. Can we expect the staff to give us information like that?

Margaret "Peg" Terry: Sorry, yes, I'm back on. Yes, well, we do look at related and competing measures as you may know. And measures that are coming forward that we are aware of, a lot of work is going on right now with new committees also. But if we are able to find out that there is an e-measure or another measure that is coming forward that relates to this group, we will really speak to that measure as well.

Richard Antonelli: OK, and just so that I'm aware, is that actually a pretty rigorous internal process or – because the wording that you chose struck me as if you're able to find out. So, should I – is there something that we should be reading into that

in terms of one committee at the NQF – or one component of staff and another component of staff?

Margaret "Peg" Terry: No, you know, basically measures come forward, but not all of them are measures that we actually bring to the committee sometimes; there's still a discussion with the developer or whatever.

Richard Antonelli: Yes.

Margaret "Peg" Terry: So, if there's a measure that is actually going to be presented, even though it may not be a measure that has gone through a committee because we are an early committee, we will find out about that those measures that are considered related, competing. And it's really also, you're talking about new measures. It's also up to the developer to also let us know about measures that are similar or that actually – they could have some form of harmonization, looking at the elements of the measure. So, it's sort of a two-part to this.

Richard Antonelli: Yes.

Margaret "Peg" Terry: I just (rephrased) that.

Richard Antonelli: Yes, exactly. I'm a big fan of parsimony and harmonization. OK, thank you.

Bob Rehm: This is Bob Rehm at NCQA. We have an answer for the question you had asked that we weren't too clear on. I was – is there an opportunity to clarify?

Margaret "Peg" Terry: Sure, please go ahead.

Bob Rehm: I don't want to interrupt the flow, but …

Margaret "Peg" Terry: No, go for it.

Bob Rehm: We kind of felt bad about that, sorry. So, this is the – so, you know, there's the NQF documentation and there's the specification that's used by providers in the program. And I'll just, if I can, just read from what's called a numerator note. And this is publically available, it's in all the CMS – you know, they have thousands of pages of documentation, but that's contained in the actual specification.

Let me see if I can abbreviate this. Let's see. So, the use of the CPT code confirms that the advanced care plan was in the medical record. That is at the point of time that the code was assigned, the advanced care plan in the medical record was valid. Or that the advanced care planning was discussed.

The codes are required annually to ensure that the provider either confirms annually that the plan and the medical record is still appropriate, or starts a new discussion. The provider does not need to review the advance care plan annually with the patient to meet the new waiver criteria.

Documentation of previously developed an advanced care plan that is still valid in the medical record meets numerator criteria. The idea is that when they see the patient they confirm that those things are still valid. And then, by using that code, they are attesting to that.

And then, if it's changed, then they would make their notes in the chart accordingly, and then use that code again to say that. You know, the code is speaking to the validity of what's contained in the charts. So, I hope that that's a little more explanatory power for you.

(Crosstalk)

Bob Rehm: We can provide that you if it would be helpful to NQF staff.

Margaret “Peg” Terry: Yes, that would be great. Thank you very much.

Bob Rehm: You're welcome.

Margaret “Peg” Terry: Any other comments on any of the measures? Any other general comments that people want to make or questions?

(Ryan Collor): I am on the measure 3171 that we didn't talk about in as much detail, I just had a couple of, I guess, clarification points for the developer. Found it at times a little bit confusing whether we were interested in 30-day follow up or 14-day follow up because the introduction to the measure seems to be focused on 14 day follow up with PCP. But several of the details later on focus on 30-day. And then, the description of the measure calculation didn't seem to really

treat it like composite as much as individual – each item individually. So, are those things …

Margaret "Peg" Terry: All right, thank you. (Suzanne), are you still on?

(Suzanne Lowe): Yes. I'll make a note of that. I know there was a reasoning behind the two differences but I'll have (Larry) bring that up for the in-person meeting.

Margaret "Peg" Terry: Thank you. Again, we're taking notes here, so we will have that. Make sure we have all the details.

Anybody else on 3171? So, if not, before we actually close out, we do want to – and make our final comments, we do want to open this to the public.

Operator: At this time, if you have a comment or a question, please press star then the number one on your telephone keypad.

And there are no public comments at this time.

Margaret "Peg" Terry: OK. And so I'm just going to, first, thank everybody and I really want to thank Gerri. She's just really terrific for us to work with. She's really very good at summarizing and for helping us and so thank you, Gerri, for your work today and for everybody who jumped on to really help look at the measures and think about the measures and bring up questions. I think it's really going to help at the meeting in a few weeks.

And with that, we're going to – we have some next steps but before we get there, Gerri, do you have any comments?

Gerri Lamb: Just a few and I also wanted to say thank you to you all. This was just such a great discussion and thoughtful and in-depth. For the in-person meeting, I just want to kind of emphasize we have one day together and so our priorities, we have to get through our seven measures. Again, some are maintenance, some are new and it will be great to have the measure developers there answering our questions.

We're also hoping to be able to have some time to talk about the Care Coordination measurements that is a hole in the gap. So I would just ask that

everybody think about that in advance. We talked about it at some length on the call yesterday, is that people on our committee have lots of great ideas and it's an opportunity to discuss them together as well as put them forward.

So just in prep for the face-to-face, if we can get through the measures efficiently, then we will also have time to talk about gaps. We'll just have to see how it goes, but I very much am looking forward to seeing all of you. Thanks, Peg.

Margaret "Peg" Terry: Thanks, Gerri. I just want to say for the – before the next meeting, we're actually going to reach out to you all again and just identify the leads for each of the measures, so – and then maybe a backup if we have more than enough people just so you know and – but let me just say this. Everybody should know all the measures because you're going to be voting on them, but I do want to give a heads up that we'll be reaching out to everybody with people that would be able to be the leads on each of these measures.

So with that, we have some next steps. I'm going to turn it over to May.

May Nacion: Hello, everyone. Just a quick reminder to please, for those who have not turned in there measure-specific DOI, please send that to us as soon as possible, and the latest should be by Friday of this week. We really need that before the in-person meeting.

And again, to reiterate, please go on to continue reviewing those measures, that everybody should be familiar with them. Also, to complete the surveys that were sent out by Friday as well so that we can update the preliminary analyses with the updated responses from the survey, which will be shared to all.

Again, the in-person meeting is on February 22nd, where we will review and recommend the measures for endorsement and hopefully to also discuss the gaps (and) measures. And then we can determine if we need a post-meeting call. That's it.

Margaret “Peg” Terry: Thank you, May, and thank you very much, everybody and have a great day and thank you for participation on this call. I think it was great. So have a great day.

Gerri Lamb: Thank you.

Margaret “Peg” Terry: Bye-bye.

Male: Thank you.

Margaret “Peg” Terry: Bye-bye.

Female: Thanks.

Female: Bye-bye.

Operator: Ladies and gentlemen, this has conclude today’s conference call. You may now disconnect.

END