NATIONAL QUALITY FORUM

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CARE COORDINATION STEERING COMMITTEE

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WEDNESDAY
FEBRUARY 29, 2012

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The Steering 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 Casey, Jr. and Gerri Lamb, Co-Chairs, presiding.

PRESENT:

DONALD CASEY, JR., MD, MPH, MBA, Co-Chair
GERRI LAMB, PhD, RN, FAAN, Co-Chair
DANA ALEXANDER, RN, MSN, MBA, GE Healthcare
KATHLEEN ALLER, MBA, McKesson Enterprise Intelligence
ANNE-MARIE AUDET, MD, MSc, The Commonwealth Fund
J. EMILIO CARRILLO, MD, MPH, New York-Presbyterian Hospital and Weill Medical College of Cornell University
JANN DORMAN, MA, PT, MBA, Kaiser Permanente
KAREN FARRIS, RPh, PhD, University of Michigan College of Pharmacy
PAMELA FOSTER, LCSW, MBA/HCM, ACM, Mayo Clinic Health System
WILLIAM FROHNA, MD, FACEP, Washington Hospital Center
JEFFREY GREENBERG, MD, MBA, Brigham and Women's Hospital
THOMAS HOWE, MD, Aetna
SUZANNE HEURTIN-ROBERTS, PhD, MSW, HRSA

CHRISTINE KLOTZ, MS, Community Health Foundation of Western and Central New York
JAMES LEE, MD, The Everett Clinic
RUSSELL LEFTWICH, MD, State of Tennessee
MARC L. LEIB, MD, JD, Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid System
JULIE L. LEWIS, MBA, Amedisys, Inc. (by teleconference)
LINDA LINDEKE, PhD, RN, CNP, University of Minnesota School of Nursing and Amplatz University of Minnesota Children's Hospital
DENISE LOVE, MBA, National Association of Health Data Organizations
LORNA LYNN, MD, American Board of Internal Medicine
JEAN MALOUIN, MD, MPH, University of Michigan
MATTHEW McNABNEY, MD, Hopkins ElderPlus and Johns Hopkins University
EVA M. POWELL, MSW, National Partnership for Women & Families
BONNIE WAKEFIELD, PhD, RN, FAAN, University of Missouri and Iowa City VA Medical Center
ALONZO WHITE, MD, MBA, Anthem Care Management

MEASURE DEVELOPERS:

DAWN ALAYON, National Committee for Quality Assurance
MARK ANTMAN, Physician Consortium for Performance Improvement
KATHERINE AST, American Medical Association
MARY BARTON, National Committee for Quality Assurance
KERI CHRISTENSEN, American Medical Association
ERIN GIOVANNETTI, National Committee for Quality Assurance
JEREMY GOTTLICH, National Committee for Quality Assurance
KENDRA HANLEY, American Medical Association

BOB REHM, National Committee for Quality Assurance
LAURA YODICE, American Medical Association

CONSULTANTS:

RICHARD ANTONELLI, MD, MS, FAAP, Children's Hospital Boston/Harvard Medical School
ARJUN VENKATESH, MD, Brigham and Women's Hospital-Massachusetts General Hospital

NQF STAFF:

HELEN BURSTIN, MD, MPH, Senior Vice President, Performance Measures
KAREN JOHNSON, Senior Director, Performance Measures
KAREN PACE, Senior Director, Performance Measures
LAURALEI DORIAN, Project Manager, Performance Measures
NICOLE McELVEEN, Project Manager, Performance Measures

C-O-N-T-E-N-T-S

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

8:36 a.m.

Welcome and Recap of Day 1

MS. DORIAN: Welcome back to Day 2 of our in-person meeting. Thank you for your participation yesterday. I think we had a really great day reviewing ten measures. I've just put up a quick recap of what you did yesterday. You approved or recommended for endorsement seven measures, and then there were three measures that were not recommended.

What we'll do later in the afternoon session is bring this slide up again, with the five measures that you've reviewed today, when you start thinking about what the gap areas are. I think I'll turn it over to Don and Gerri, to see if you have any comments before we get started with our NCQA measures.

CO-CHAIR LAMB: Good morning, everyone. Hope you had a good evening and welcome back. Just to take a look at our

recommendations so far, and as Lauralei was saying, we're going to bring these back later when we talk about areas that we think we would be beneficial to improve care coordination and outcomes, is I think some of the trends in this is that we've got med rec items so far, and we're going to be reviewing more today, as well as transitional care measures and that's pretty much our categories right now.

So as we move forward into looking at priorities and gaps, we're going to be bringing this back up and taking a look at what else should we be looking at, where are priority areas, so that not only are we going to be reviewing the remainder of the measures and looking at, let me get the right language here, related and competing measures, we're going to go into what should we be measuring in the future, and I don't see Julie here, but Julie's gimme-mores.

So we have a busy day. Glad

you're all back, and Don.

CO-CHAIR CASEY: Yes, I just wanted to say again thanks to everyone for yesterday. It was the first time in my experience that we've used the method that we applied using the criteria for evaluation.

I thought it went exceptionally well. I was very pleased at how much we got through, and I hope you felt that that helped kind of guide our thinking and our discussion, because I know in the early phases of NQF, it was much more free form.

So while free form discussion is still important, I think keeping to the sort of structure of evaluating and voting on measures was really good, and I know the staff is looking for qualitative feedback about how we can make that process go better.

But I do know that in the discussion yesterday, we came up -- we bumped up against one technical issue, and we've actually already sort of made a change in

that. I was going to ask Karen to just review that with you quickly, so that you can understand.

It has to do with the first category, those three level, those three level decisions that we went through. I think the good news is we're not in any -- we're not creating any problems for ourselves. But once you hear sort of what we think the process will be today, I think it will help. So Karen, you want to --

MS. JOHNSON: Yes, we talked yesterday about the problem with some of the measures having very little evidence, and we also talked about the potential exception to the evidence criteria, if you felt that there just wasn't any evidence or not enough to make a decision, and you wanted to apply that exception.

So for today, let me tell you what we're going to do today, that will clear things up, and then we'll go back and clean up

a little bit from yesterday. So today what we're going to do is we're going to change the way that we're voting on evidence, and the way we're going to do that is yesterday, we asked you about the evidence, and particularly to think about quantity, quality and consistency, and then based on your feelings about that, say either yes or no, that you passed evidence.

Today, what we're going to ask you to do is think about quality, consistency and quantity, the three things again. This time, we're going to give you a choice between yes, no or insufficient, okay? If a majority of people think that it was insufficient to be able to say yes or no, then we will decide if you want to apply the exception criteria, and if you do, then we will vote on the exception criteria.

That's really what we did or close to what we did yesterday afternoon, at the end of the day. But that will -- that way, there

will be no questions at all, and it will be very transparent about what we think. So hopefully you guys will like that change. Okay good.

For yesterday, I think the question is were there any measures where you felt that you were applying the exception rule, even though we didn't formally vote that way? If so, what might some of those measures be? I think the --

(Off mic comments.)

MS. JOHNSON: Bring up the voting slide?

(Off mic comments.)

MS. JOHNSON: Right, and I had done a little bit of homework on this yesterday. The ones that went down are probably the ones that might be most concerning, and that one was the bone scan one, and yesterday, just to remind you, that one failed on impact.

So that one, regardless of what

you would have said about evidence, that one went down. The other one was the biopsy follow-up, and that one -- that one might be one that we want to think about a little bit, and the other ones, I didn't think that there was a thin evidence on the other ones, but you guys can tell me.

CO-CHAIR CASEY: Well, I think to help, just so that we are parsimonious, our judgment, I think, was that it probably was thin to begin with. But we could consider voting on that measure relative to this last issue that we didn't apply.

So I guess we just want to get sort of general comments. We don't want to spend a lot of time debating it. But maybe we can have a show of hands? Who would like to vote on that measure, the biopsy measure from the dermatologists, using the fourth criteria, the exception rule? Who would like to vote on that?

(Show of hands.)

CO-CHAIR CASEY: Just one. So I think that was our judgment, was that probably we weren't. So I think we'll just let that lay as it is, and then today, what we've done is we've added in this nuance to that third question, so that it becomes a binary decision about how you want to proceed. So it's built in rather than separate to the decision.

So does that make sense to everyone? So I think I'd give the group good kudos for sleeping on that solving it on a good night's rest. So thank you.

MS. JOHNSON: Okay. Everybody ready to start up again? Okay.

MS. DORIAN: Just a note before we get started. We are changing the order of the measures around just a little bit. We're going to be starting with 0326, which is the Advanced Care Plan, and I'll have, before we get started, I'll have the NCQA folks introduce themselves, and I'll just check to see if we have anybody on the phone.

MEMBER LEWIS: Hi there. This is Julie. I'm on the line.

MS. DORIAN: Hi Julie, thanks.

CO-CHAIR CASEY: Welcome, Julie. We're glad you're on the line. We miss you in person, but thank you for calling in.

MEMBER LEWIS: Absolutely. Looking forward to it.

CO-CHAIR CASEY: And don't feel shy about jumping in here.

MEMBER LEWIS: Oh, I won't. We had that experience yesterday.

CO-CHAIR CASEY: I think in the interest of our measure developers, we decided that initially we were going to go back to doing the med rec measures, but because it turns out that it is -- did I get this right -- that NCQA 326, Advanced Care Plan, was done in collaboration with the AMA/PCPI, and so we have both parties here.

So we want to do that first. So the order will be Matthew, you'll be on the

hook to present that, and then we-- Lauralei help me. Are we doing the medical home one or can we go to med rec?

MS. DORIAN: We can do med rec after that.

CO-CHAIR CASEY: Then we'll do the 553/554 and 097. So those people can sort of get themselves queued up for that, and then we'll end up with 0494, and that will complete the first part of the measure set.

MS. DORIAN: So we'll start with 0326, and then we'll actually jump to 0097, because those are the two PCPI ones.

CO-CHAIR CASEY: And do we want to maybe ask -- we know our AMA counterparts from yesterday. Do we want to ask the measure developers on the side here to introduce themselves for us please?

MS. ALAYON: Hello. My name is Dawn Alayon. I'm a senior health care analyst at NCQA.

MS. GIOVANNETTI: Erin

Giovannetti, research scientist. I've spoken with many of you on the exciting work group calls.

CO-CHAIR CASEY: Please use your mic, because we're -- and I know we're having a little technical problem with it, but this is being recorded. So I think it would be useful to be sure we get your name captured.

MR. REHM: I'm Bob Rehm, Assistant Vice President for Performance Measurement and NCQA.

MR. GOTTLICH: Jeremy Gottlich, senior health analyst at NCQA.

CO-CHAIR CASEY: Thank you, and we'll just make note that we have Mark Antman and his group from AMA/PCPI here as well. So thank you for being here. So Matthew, do you want to lead us off for the day?

Measure 0326

MEMBER McNABNEY: -- a graduate of our fellowship program, so wonderful to see that. So is a very important measure. Our

Work Group discussed it and had some, I think, interesting comments, and we look forward to some input from NCQA.

It's a measure that looks at older people exclusively, important to note in the Medicare population, in the important subject matter of advanced care planning. No question about the importance of that, as far as in the public eye and in the health care world.

The measure itself looks at the reporting or the patients who have had advanced care plan or assignment of a surrogate decision-maker, or declining to do so, to participate in that. So that's the numerator population. The denominator statement is all those 65 and older. So it seems to make sense from that regard.

Regarding the importance of the measure and the performance gap or the evidenced performance gap, that's fairly strong as well. Evidence that was included in the write-up shows that the majority of patients in this

population aren't having this done, and it's not being documented. So there's -- and given the importance that is also described, the performance gap is real and measured, and we all agreed on that.

There also is particular concern about the performance gap that would be noted in those older people with cognitive impairment, which is, as we know, is a fairly large percentage of the older -- well, relatively large percentage of the older population, which increases with advancing age and the relevance increases as it approaches end of life, of course.

So that subpopulation is an important one to note as well. Regarding the measure itself, there are comments on -- so to summarize the evidence, the group was -- the evidence of this measure, it was rather mixed, and given the comments when we opened about the evidence of what might be -- part of the reason the comments were mixed.

The evidence of the importance in the value of doing advanced care planning is strong and plentiful. I think what some of the members of the subgroup were not so clear at and maybe scored at less is the evidence that this particular measure will improve and enhance that happening.

So evidence is strong for the importance, but is the evidence maybe not so strong for this particular measure getting to that goal. But others can comment on that in the discussion.

Regarding reliability and validity, the reliability was questioned, and a couple of people on the subgroup commented. The inclusion in the numerator was, it appears, and NCQA folks can comment, it appears is driven by the coding of the conversation, the CPT coding of the conversation, which I know Jeff and others commented.

It's not myself also as a clinician, not typically used. So if that's the primary

or maybe even in the sole method of identifying those who have had this, that could be an important flaw. We just need clarification on that from NCQA.

Then if that's not the case, if it is other methods of finding documentation, then the whole issue of the practicality of that and the labor intensity of finding the documentation, there's that complication. So either way, there's important limitations that we need to address before in the discussion.

Also regarding reliability, there was a good description of the reliability assessment of the instrument, which was assessed as high.

The question again is was the reliability testing of people who went and evaluated the coding of the discussion, was it confirmed that the coding was accurate, or was it reliability testing of the documentation of the discussion against the coding.

So how that was actually done may be

in here, I didn't catch it. But that would be helpful to clarify how that was done. The validity testing was done through expert panel. Certainly seemed appropriate the way, you know, convened a large interdisciplinary clinical panel to agree that this measure was important.

It was a fairly simple, but I still think, effective way of getting expert consensus opinion that doing this is a valid and important technique to measure completion of advanced care planning, and that was supportive of that.

So the usability and feasibility, again, gets at how I think the public's, or the use of this is a quality measure, if these other issues are addressed.

We felt both the usability and feasibility of this measure to improve health care for older people with regard to end of life care planning was certainly strong and appropriate. Just some need to address those

technical aspects about how the information is gathered.

One of the, I think, important process issues for today is to be sure that when we speak, we identify which of these criteria, and you may be speaking to more than one, you're addressing. So this will be helpful to the measure developers too, to stick to which part of the evaluation you're going to provide support for.

So with that, just as a reminder, can we ask for any comments for other people in the work group that -- or with Matthew on the call? Jeff.

MEMBER GREENBERG: Yes, I was on the call as well, and as Matt said, my concern was with the validity. If that is, to me, the measure measures what it purports to measure, then I want to be sure that that code is checked. It means it was done, and if it's not checked, it means it wasn't done.

I want to see some kind of evidence

that someone has looked through enough charts, to say yes, the codes do correlate with whether or not this activity was done, because otherwise again, it's a measure.

Like one of the ones, I forget which one, it's really a measure of box-checking, not a measure of an actual conversation with a patient.

CO-CHAIR CASEY: Other comments. Dana.

MEMBER ALEXANDER: Yes. I think my comment applies to more than just one area. As I started reading this measure, I got confused. I had to keep reading, and that's around the term advanced care planning, where I believe that's being interpreted for advanced directives.

When I think about that term advanced care planning, to me that is much broader in scope and advanced directive as being a subset of that. So I think it's confusing. I think it's going to be

confusing, that term "advanced care planning," as applied to advanced directives alone.

It's going to be very confusing to the industry at large. Then the other aspect of this too is again that if we -- again, thinking about applying this across what care settings, you know. Hopefully all care settings, to be reviewing and looking at does a patient have advanced directives, and then not to have that conversation.

And then who are the best stakeholders to do that as well? That is maybe a physician, maybe not. I think, you know, it should be flexible enough that it would consider the care team. Maybe that would be a social worker, maybe that would be a nurse, you know, depending upon the situation and the setting.

So it's presenting limitations to me in my thinking about how this would actually play out on behalf of the patient.

CO-CHAIR CASEY: You know, I think

that's a critical point, and I know, just in my own health system, we struggle day to day with use of terms "advance care planning" or "palliative care," which have a variety of different meanings to people.

But Dana, would it be reasonable to expect that this part that we're talking about is a segment of advanced care planning? In other words, would that be a helpful clarification?

MEMBER ALEXANDER: Yes, for me.

CO-CHAIR CASEY: So that's feedback for the measure developers. I think you have to be very careful about these terms, because there's not clarity on what advanced care planning is. We don't have 100 percent agreement on what these things mean, and most people have no clue and interpret them the way they see fit.

So we just have to be sure that that is clarified. So I think that can be done in probably the description of the measure,

rather than the technical aspects. Is anyone uncomfortable with that? Okay. Other comments?

(No response.)

CO-CHAIR CASEY: So why don't we see if the measure developers have any thoughts or enhancements. Again, keep your comments brief and to the point. They have this information, do they not, the measure developers?

FEMALE PARTICIPANT: They do not have them.

CO-CHAIR CASEY: They do not, so --

FEMALE PARTICIPANT: Other than this is what we did on that.

CO-CHAIR CASEY: This is what we did on the call. So I think you got a chance to see that. Did you get a chance to see what was up there?

DR. GIOVANNETTI: No, we've not seen this.

CO-CHAIR CASEY: Well, why don't we just -- you want to start from the top, just

so they can maybe take two seconds to just review kind of this?

DR. GIOVANNETTI: But I can, you know, I can speak to -- sorry. Oh, I'm evidently not coming through as an echo.

CO-CHAIR CASEY: Why don't you just take a look at how the group sort of did a straw poll. This is not the ultimate vote, but how they were thinking and what some of their comments were, and maybe just take two seconds.

I think one of the issues was reflected in Matthew's presentation about two related to the evidence, and again, how that relates to the usability as being the issue. I don't think there was any debate about importance.

DR. GIOVANNETTI: So speaking to the evidence and whether or not this measure will actually help to increase the number of patients who discuss advanced care planning with their clinician, it will point to the

fact that the performance on this measure is very low.

Almost three-quarters of patients did not have an advanced care plan, and this measure is also in the PQRS set, meaning that physicians choose which measures they want to report.

This is not across all physicians. So this is of physicians choosing that they want to report on this measure, knowing that they are reporting on this measure, and it's still very low.

So even though I agree this is a very low threshold, we're not even really matching that threshold very well. So additional measures in the future may get at some of these larger concepts, like really talking about advanced care, planning for the future, palliative care.

This is a minimum threshold that I think we're showing, and the performance on this measure, it's not being met, even this

minimum threshold. So I think that there's still a need for this measure, because it's telling us something very important about a performance gap for physicians.

CO-CHAIR CASEY: Matthew.

MEMBER McNABNEY: That's a great clarification, and I didn't realize that people, you know, that people chose.

So there was a select population, which makes me think even moire strongly that what you were saying, Jeff, that people believe that in their practice they're good, or they believe that very likely there's something missing in how it's being captured, because I think they're really, 75 percent of them aren't being discussed.

I don't know that I would be putting that forth as the measure I want to be evaluated on. So I wonder if there's something about the capturing of it that is flawed. I don't know.

DR. GIOVANNETTI: Well, I will hand

it over to the AMA team, to talk about the validity testing, in terms of the -- and the reliability, the CAPA agreement that was put in the report, since they did those. They calculated those numbers for us.

CO-CHAIR CASEY: Do you want to comment? Can you clarify the question? And you might want to step over here to the mic for us.

DR. GIOVANNETTI: Oh. There was a question raised by the committee as to whether or not the reliability testing looked at simply whether or not a box was being checked, or whether or not the CPT codes matched the event actually occurring and documentation in the medical record.

MS. CHRISTENSEN: We don't typically require them to actually find a CPT code, because it is manual abstraction that the testing project was done on.

But they would need to find that there was documentation, that it was done not

just a checkbox but that's usually included in the medical record what they actually discussed. Did that answer the question?

CO-CHAIR CASEY: And for the record, can you identify yourself please?

MS. CHRISTENSEN: I'm sorry. Keri Christiansen, AMA/PCPI.

CO-CHAIR CASEY: Great. So Jeff.

MEMBER GREENBERG: Yes, I'm just, I'm confused. The numerator says there's G codes or some codes checked off. But is that not the case? Is there actually a medical record review for this measure?

MS. CHRISTENSEN: No. This record, this measure is based strictly off of CPT-II codes, and part of that is that this is a measure that physicians could choose to report. So one would assume if they're choosing to report on this, they are using CPT-II codes.

Even though I know that that's not the most common practice among physicians, the

validity tests or the reliability testing which you see up on the screen there, that was done with medical record abstraction, and matching that to the performance reported on the measure.

MEMBER GREENBERG: So that's inter-rater reliability, which would seem to be pretty easy. If it's a code, it's pretty easy to make sure everyone's recognizing the same code, right? I guess I'm getting at the validity and not the reliability, of whether that code actually equals the activity we're discussing.

MS. CHRISTENSEN: So the testing project we did was to have two human beings go into the medical record and make an independent assessment of whether or not the patient met the measure, and did not meet the measure, or four measures, where there are exceptions, whether the patient was an exception to the measure.

So it is possible to report this

measure in claims using CPT-II codes, but we wanted to determine whether it was possible for two people to actually determine whether the patient should be a measure met exception or measure not met, which would then go in the CPT-II code as one of those categories. Does that make sense?

MEMBER GREENBERG: I think so. It's interesting. You did the reliability testing -- you did inter-rater reliability testing. Did you also in the same process do validity testing, that if in fact these two people or one of them found the documentation, that it matched what was coded?

MS. CHRISTENSEN: I'm sorry. I really did think you guys were going to do the other measure first, so I do not have that up. Could you roll down to the between --

MEMBER GREENBERG: Because under the validity, it would be the expert panel. But it seems like you may have done more than that. I'm just to trying to flesh that out.

MS. CHRISTENSEN: There's a section that talks about two different forms of reporting. Could we look at that? It's not. Different modalities of reporting.

(Off mic comments.)

MEMBER GREENBERG: And then I guess while we're looking at that, I guess the question I have to the group is, you know, fair enough if it's meant specifically for provider groups that choose to do this and choose to use these codes.

What do we think about that in terms of usability? If I'm a patient or if I'm the press or the government. I mean it's sort of a measure that is only going to be used by probably a relatively small, select group of providers that choose to code in this way. Is that usable enough to warrant endorsement?

I don't know. I mean you could see providers saying well, we do this. I don't know if people are really going to advertise that they're very good at advanced care

planning. But say they were, you know, that could actually be misleading, if most people don't even know about it and don't even code in a way that they could.

So you know, that's fair in terms of validity, if you can assume that providers that choose to do this will understand how to do it. But is it a usable measure, if that's the case? I'll stop talking.

CO-CHAIR CASEY: So Tom has a point. We have several people in the air here, so --

MEMBER HOWE: Yes. I think that in the numerator details, it does specify these new CPT-II codes, 1123-F and 24-F, as to whether they met or had an exception.

I think that's a strength. I mean the code is described; it's usable, and it's sort of binary that they did it or they didn't, and defines what they did or didn't do.

Now whether you choose to be reporting this particular measure is an issue

for those in the community, not so much for us. So I would ask, though, how many folks are reporting these two codes? I mean is it 1,000 across the country? I mean are these codes being used, and are the intermediaries recognizing them?

CO-CHAIR CASEY: Yes.

DR. GIOVANNETTI: So we have this information in the report that one percent of physicians in this program choose to report on this measure.

CO-CHAIR CASEY: One percent, right?

DR. GIOVANNETTI: One.

CO-CHAIR CASEY: One.

DR. GIOVANNETTI: And that was in 2008, the year for which we have the most recent data available.

CO-CHAIR CASEY: I've got Jann and then Dana, and then Anne-Marie, then Matthew, then Eva. Hi Eva. Jann.

MEMBER DORMAN: So I would just like to express my support of the measure in the

way it's currently conceptualized. What I see the measure as measuring is the conversations, and it's the conversations that have the value to the patients, and helps align the treatment with the patient's values and choices.

The fact that the advanced directives, the medical/legal subset can fit into that is great, and I totally agree and support with the idea of clarifying language, so people are clear. But I personally support the idea of planning and conversations as the ultimate event that's being measured.

With respect to the coding, this may be a situation where the measurement needs to lead the practice, and while the validity and reliability for the current clinical practice may not be what we wish it was, if there's a strong measure in place that measures something what people really care about, then that validity and reliability will hopefully evolve. So that's my perspective, thanks.

CO-CHAIR CASEY: Dana.

MEMBER ALEXANDER: So from a validity and usability perspective, where this measure is not working for me is that again, that it seems like we're focused on the, you know, outpatient setting physician practice setting, versus again, across the care continuum.

So from a care coordination perspective, I'm looking at this in a broader sense, that it's an important measure. But we think about in an inpatient setting now, there's Joint Commission requirements around, you know, advanced directives, you know, documenting that, you know, have you asked the patient about advanced directives, and if not, if they have interest into providing the right counseling.

That is not typically provided by a physician but another member of the care team. So this measure doesn't seem to capture that, and perhaps that's just not, you know, that's not the intent. But again, looking at this

from a broader scope, it just -- I'm struggling with the fit.

Then again, if it is going to focus on the outpatient, you know, clinical practice setting, then I think again, the language needs to be, you know, clinical provider, because it could be a PA, it could be a nurse practitioner, and again a social worker, you know, even in a physician office setting as well too. So those are some of my struggles.

CO-CHAIR CASEY: I just, a light went on in my head, and Jeff, maybe you can participate in this. It's now law in New Jersey for us to implement what's called physician orders for life-sustaining treatment. I think in Massachusetts they call that medical orders for life-sustaining treatment.

I've become aware, I think, that Massachusetts has passed a similar law, but my question then is, to the measure developers, and this is something that's probably going to

be put into place pretty quickly, how could that intersect with this measure?

So I'm just, I'm not asking to sidetrack this measure. I'm just trying to let you know that the train has left the station on this from the standpoint of enabling a much better standardized approach to documenting life-sustaining treatment through orders, that then are transmitted through the care continuum.

I'm not sure how aware you are of that, but I think it would be worth studying. I don't think it's going to change anything we do here. I'm just trying to suggest that that may be a game-changer on this measure in the future. So yes.

DR. GIOVANNETTI: So thank you. That's very good information to have. I will just clarify that this measure is specified for physician level reporting, and while I appreciate that this can be done at many different levels and in many different

settings.

Those are why we need additional measures, which look at different levels of accountability, and in fact we have such measures in the HEDIS data set, that look at a higher level of accountability, which have more flexibility in who it is that discusses the advanced care plan with the patient.

But understanding the limitations of this measurement set is really to report to clinicians about their performance. It is trying to improve the performance of individual clinicians. So that's why this is specified really at the physician level.

We're not in any way saying that this isn't something that should also be done at many different levels, and with a team-based approach. But I would think that anybody would agree, that even if you have discussed this with a social worker or a nurse practitioner, your physician should probably still be aware of it, and should document it

in the medical record, that there is an advanced care plan.

CO-CHAIR CASEY: So Anne-Marie and then Eva and then James.

MEMBER AUDET: So I'm still concerned about the fact that we're still using a CPT code for this measure, because unlike yesterday, when we were talking about our transition of care record, where there were specific areas that we were looking for, in terms of what was the content, here we're not looking a content really. We're looking at a code.

So it leaves a lot -- it leads to potential lots of variation in what people are interpreting as advanced care plans. In the document there are some, you know, various content areas, conversation with patients, instructional advanced directives, durable power of attorney.

So there are components there. But I don't think we're capturing this with a

code. The other thing is when I'm thinking of impact of this measure, it's really important that in fact this information be in the medical record.

So if a patient arrives in the emergency room and no one knows the patient, that this information be there, not in the form of a CPT code, but in the form of content. So that's where I'm a bit concerned about the measure at this point. I think it's a really important measure, but it's how we're capturing the content that's an issue for me.

CO-CHAIR CASEY: And Anne-Marie, that's entirely the goal of having orders for life-sustaining treatment in place, so Eva.

MEMBER POWELL: Thanks. My concern is very similar to Anne-Marie's, and just for a point of clarification, I want to ask a question. The context for all of our discussion about all of these measures, I'm assuming, is from the -- looking at these through the lens of a more robust quality

measurement environment, that's enabled by Health IT. Is that true, or are we still --

CO-CHAIR CASEY: Well, I think that's important, for important consideration. Certainly when we discuss things like care transitions and medication reconciliation, that can inform the discussion. But that is not a deal-breaker, given the state of where we are.

So I think it's certainly important to highlight that Eva, but you know again, that could be too futuristic for us to wait on this. But any insights you have about this are welcome.

MEMBER POWELL: Well that helps, I think, a little bit, because I totally agree with the importance of the measure, and I also agree with Jann's comment about perhaps this is a case where the measurement will guide the practice.

But that brings additional concerns, I think, about the use of CPT codes, which I

thought that we were trying to get away from in quality measurement, and then also it sounds like the reliability and validity of the measure was determined based on manual chart review, which is absolutely something we're trying to get away from.

I just, I'm concerned about where this fits in the context of this more robust measurement system, for all the reasons that have already been mentioned, but also the link to meaningful use is that meaningful use is extraordinarily weak on advanced directives, and in fact, that criterion has not been advanced at all from Stage 1.

The reason given were some of the reasons you've mentioned, is the differences in state law. So I'm just wondering, I'm kind of putting that out there, again consistent with Jann's comment, that I think that this is an opportunity for this group to show leadership, both in the practice world but also in the policy world, that this is

information that has to be captured, but it has to reflect something that's actually of value, and it has to somehow connect with the world of the future, while still being feasible in the current world.

I'm just not convinced that this iteration of this measure is it.

CO-CHAIR CASEY: Yes, and I think we always end up with the Leftwich femoral artery, Casey, "It's a Wonderful Life." I think I'll call it it's a wonderful femoral artery scenario. But I think we need to keep that in mind as well. So James.

MEMBER LEE: Well, I support this measure for a variety of reasons. I think for one thing, we talked about evidence of documentation, electronic form. The reality is each state has its own orders. There's 50 sets. At some point, this benefits the patient, meaning patients should carry this electronically somehow, and that it transmit across states with or without notary and other

elements. It's a complicated issue that has yet to be defined.

Secondly, when we ask about where providers are in terms of this culture of talking about this subject, just raising it, we're nowhere near where we should be. Clearly, when I talk about this with patients, the first thing I do is assess whether they're on this journey.

Everyone is different. Some people are not really to even sign the form for you, and that's why we have the exclusion laws, the exclusion criterion here. I think because of that, I support this measure to begin the journey of quantifying this, to illustrate the importance that this conversation take place.

And the legislative portion eventually, I think, will sort out. Advanced care planning, what it exactly defines may take a long time to sort out nationwide. But still it's a very good place to start, and it's consistent with what I see when we're

seeing patients, talking about this subject.

CO-CHAIR CASEY: Thank you, James. Lorna.

MEMBER LYNN: I appreciate the concern about what's behind the checkbox, with the comments that Eva and Anne-Marie made about the CPT codes being used. But am I not correct that the PQRI measures and NCQA have an audit process that is mandatory for these?

And so you have a mechanism of looking at what's behind that checkbox here, which could be informative. But I also appreciate Jann's comment about measurement perhaps leading practice in this area.

CO-CHAIR CASEY: So there is an audit process; correct?

DR. GIOVANNETTI: I believe CMS audits. I'm going to let Dr. Antman answer that question.

DR. ANTMAN: Yes. Unfortunately, we don't get the details of CMS's audit, but I believe that they do, they do audit the use of

the CPT-II codes. But I do want to reinforce the point that although the CPT-II code is used for reporting whether or not this measure is met, it is only to be used if in fact the documentation is in the record.

If you look back, I wonder if we could scroll up to the actual numerator language, please. There we go. As it says, patients who have an advanced care plan, etcetera, document it in the medical record. The intent of the CPT-II, the intent of all use of CPT-II codes is simply as a mechanism of reporting that something has been done.

In this case, the something is the actual documentation in the medical record, that there has been discussion of an advance care plan. So simply to reinforce the idea that it's not just the code. The code is just a means of reporting that there is documentation present.

CO-CHAIR CASEY: Thank you for that clarification. I have Russ, Jean, Marc,

Matthew and Jeff. We still have a long way to go here.

MEMBER LEFTWICH: I agree with Eva, that this isn't it, but I still feel that this might be an appropriate first step, and I don't want to be a great advocate of CPT codes, but it is at least an electronic data element that we can capture. There were several measures we discussed yesterday, which maybe I should have made the point on feasibility.

But the things that we were talking about capturing are not going to be easy to capture, even if they're in an electronic record, because they're not a discrete data element at all.

So I think this may be an appropriate first step. I guess one of the real problems with CPT codes, even though they're capturable, is they're only going to get recorded on one encounter probably, and not likely if the advanced care plan, advanced

directive already exists, to get repeated in an encounter or that would be my guess.

Also, with respect to the one percent use, if that's all physicians, there are a lot of physicians who wouldn't choose this as a measure, a lot of physicians or specialists whose patient population simply is not over 65 might not choose this. That shouldn't preclude it from being a good measure.

CO-CHAIR CASEY: So you're moving your thinking from is this in a medical record to who's coordinating the care for the patient across a spectrum of an episode, for example. I think that's kind of what you were saying would be the prize.

MEMBER LEFTWICH: Yes, and certainly it is care coordination, in that much of the care team needs this to be established, but are not going to be the ones to do it. The primary care physician presumably would be doing it for the whole care team.

CO-CHAIR CASEY: Jean.

MEMBER MALOUIN: So first of all, I just wanted to say I'm very supportive of this advanced directive process, and we have a large initiative going on in the state to actually do better at this, because we don't do very well.

My concern is that if it's being used as a physician performance measure, the reality is that as more of us have funding for care managers, and we actually work with nurses very closely as part of the care team, those are the folks that are going to be part of the care team, those are the folks that are going to be doing, you know, spending the majority of the time with the patient, going over that material and perhaps getting the form documented.

So I would hate to think that one of the unintended consequences would be that, you know, if someone other than the physician was doing this, and the organization was doing

very well, that it wouldn't be captured. So I don't know if there's some way we can address that, because I do think this is very important to move forward, but I'm not sure this captures it exactly.

CO-CHAIR CASEY: Good point. Marc?

MEMBER LEIB: I have a couple of things. One is I'm very supportive of the measure itself. The numerator just says that there is a -- the advanced directives are in the chart. It doesn't say the physician actually was the one that did it.

So as long as they have it recorded in their chart, which means it can be a case manager, it can be a nurse; it can be anyone else who does it, and every physician who actually puts it in their chart can record that it's in their chart. Remember, they're not being paid for doing it; it's just they're recording that it's in there.

So that's it. I think it's important that it be, it does move across the

continuum. More people can have it. There can be hospital records, there can be other things eventually that will have these things.

But I'm a little confused, and that's easy to do, because someone said that they're trying to get away from both a medical record manual abstraction, which is very difficult, and they're also trying to avoid the use of a code set.

I'm not sure what else there is. If you're not using a code and you're not doing manual abstraction, how else is the information going to be obtained? Maybe I'm missing something. I mean I'm not trying to be argumentative. I just don't know what the third -- what?

MEMBER ALLER: It's which code set versus a code set.

MEMBER LEIB: I think that's true.

MEMBER MALOUIN: Ideally, I guess it would be extracted, extractable from an EHR in a perfect world, without a manual process.

But I guess my concern would be if we were using CPT codes, though, that would -- as the marker for whether it was done or not, I think that would be tied to a physician, wouldn't it?

MEMBER LEIB: No. It's any practitioner. It's not just physicians. Any practitioner, and in fact hospitals use CPT codes for outpatient use. ASCs use CPT codes. Now whether the Category II code is reported by them or not, it is reported by physicians for purposes of CMS payment or not -- either supplemental payments or eventually in the future not being dinged on their payments.

But anyone could use a CPT code in that respect. It's not a specifically for a physician only. I'm not trying to speak to the AMA, but I think if I'm incorrect, you'll correct me.

CO-CHAIR CASEY: So I'm going to let Chris jump to the head of the line.

MEMBER KLOTZ: Thanks. I think my

comment is short. I support this measure based on what Jann was saying, and I think we've seen in our part of New York state, in a community effort working on advanced care planning over the last I don't know how many years, seven years, that a lot of times physicians in communities don't know that they can bill a CPT code.

So I think that being able to have this measure and tie it to a CPT code would help inform the medical community that they can actually include this as part of the care they're providing and bill for it.

CO-CHAIR CASEY: I'm going to let Alonzo go next. Mark, do you still have a comment? Okay.

MEMBER WHITE: I guess my concern is about updating, because I agree with what Jann said, and I think it's great if it's in the record. But if you're just checking a box, it means it's not updated. Oftentimes, as a person goes through the continuum of advanced

care, their desires change.

I think you need to be able to document that, and maybe this should be based on -- it should be done every 12 months or something like that. But just to kind of leave it out there and you just check a box, that has me a little bit concerned.

CO-CHAIR CASEY: Matthew.

MEMBER McNABNEY: I have two comments. One of them was along those lines, because this was -- the window is 12 months. So you know, that wasn't done, and you see you evaluated and it was 14 months ago, you may or -- as it currently says, you may not readdress it and document it.

So even though they have one, it would have the appearance of not meeting the standard. Maybe I'm misunderstanding it. So unless it was expected that it was done annually, you would miss that window. That's one comment and be out of the numerator.

The second one is is that I think,

regarding this issue of the codes, and you know, your comments about the coding's done, the documentation is there. So I think the problem with -- being in the numerator is not the problem. It's not being in the numerator. So where the discussions are actually being done but not coded.

So I don't have any particular problem with what the submitted code means, or is it accurate or really reflects, although what it captures is open for debate. But I think that probably reflects that it's being done.

But I suspect that it's being done also other times, and not being coded. So the rates will be artificially low. But that, I think getting to the measure driving the practice, that people, maybe there's a window, where it's under start-up or physician practices are being notified that to be given credit for this, you have to use CPT codes every 12 months, and then for two years it's

in a temporary phase-in of the period or something.

CO-CHAIR CASEY: So I just want to be sure. Alonzo and Chris, are you -- you're fine. Okay, good. Whew. Jeff and then Kathleen, and Julie, I'm going to ask you too soon.

MEMBER GREENBERG: So I just wanted to address what Jann was saying before. I would love to see this body sort of do real policy-making, and pull providers and pull the country towards doing more advanced care planning. I have no problem with that.

But I would hate to see us pull the country towards a heavier reliance on coding to document what we do. The measures we discussed yesterday were pulled out of the medical record, and does have the disadvantage of requiring chart reviews, but at least it's accurate and you're seeing what actually occurred, and it allows the measurement to be done by EMRs, when they're available and

ready.

So I want to see if we can pull the country forward towards managed care planning. I completely agree with that. But pulling the country, I mean I think we need to move away from coding period, and more towards documenting, hopefully in EMRs, and having that dictate what we do, not coding.

And yes, you could argue that just checking the box in EMRs is the same as checking the box in a code, and in some ways it could be. But at least that checked box is available for the whole team to see, you know.

I don't have a record of whether someone once billed for a CPT in the past. That doesn't help me as another provider at all. It's purely done for the sake of measurement. It is not part of clinical care.

CO-CHAIR CASEY: So I just want to be mindful of the fact that I think we've sort of talked about the checked box issue quite frequently here, and I think we've captured

the nuances of it.

So I would hope we don't get, because we've got four other measures to get through here. So any new comments, Kathleen, about what we've missed?

MEMBER ALLER: Well, I guess what I wanted to do is provide input to the measure developer, based on a couple of the themes we've heard. We've heard that we need leadership. We've heard this is a good thing to do. This is entirely consistent with the inpatient measure for meaningful use, which is not specified as a quality measure, it is not specified precisely.

I would like to see this, the measure developers, take a leadership to develop this measure in a way that's consistent with what you could do in the meaningful use program, for both ambulatory and inpatient EHRs, coded using SNOMED for that numerator, and then get -- and then to see NQF take leadership in having that

adopted, instead of this silly measure that is non-specific, and then we'd have something measurable and useful that we could compare.

So I'm entirely supportive of direction, but I think the way this is specified now is limited, and I'd like to see the measure stewards take that leadership role in that where we need to go with the measure.

CO-CHAIR CASEY: Okay. So I think the measure developers are getting lots of good feedback here. I want to stick to our vote that's coming up soon, so that we're focused on the prize here. Denise.

MS. DORIAN: I may make an unpopular statement, but I thought the coded data was based on the documentation in the chart, because a lot of what I do and some of us in this room absolutely rely on that, and it starts with the documentation -- or I'm wrong.

It starts with the documentation in the chart. If there's a code without documentation, I thought it was fraud. But

that's just me.

CO-CHAIR CASEY: Okay. Jeff, do you have a comment?

MEMBER GREENBERG: I think there's a lot of subjectivity in what people code. What I'm more worried about -- I'm not so worried about if people code, it's not there. I am worried that people who do it won't code, which is not fraud. It's just not coding something that you -

CO-CHAIR CASEY: So Julie, do you have any comments?

MEMBER LEWIS: Just one really quickly. So first I'll say I agree, importance very high, feasibility, you know, a little touchier. But my one question was I see the original endorsement date was 2007, if I'm reading that correctly.

So I guess I'm just wondering are there other measures that are a little more advanced than this in this area, that we're just not seeing today, or has it been five

years and we're still talking about kind of this well, it's a good place to start measure.

CO-CHAIR CASEY: I'm going to let Helen take that one.

DR. BURSTIN: I wish I had better news. There has not been a lot of new development. I'm hoping some of the developers at the table are working on some things. We did, as part of our palliative care project which we just did, have some measures that get more at patient preferences, but specifically those in palliative care and end of life.

I think there's a need to go way beyond that, which is still, I think, a major measure gap.

CO-CHAIR CASEY: And I think NCQA has some symptom management measures as well, that I think were approved.

(Off mic comment.)

CO-CHAIR CASEY: Okay. Gerri.

CO-CHAIR LAMB: This is more of a

follow-up Helen, to you, which is I think a lot of the discussion, as I was hearing about it, is an important topic, but not where we want it to be.

It's five years old, and what we're seeing is it's, you know, it's the baby steps we talked about yesterday, but not anywhere near team-based, continuum-based care coordination, focused improving care, all the stuff that we want to see the field go to.

Give us a little balance here, in terms of the pros and cons of continuing to move forward an inadequate measure.

DR. BURSTIN: Right. I think those were great questions. I think that's why we have all of you around the table. This is really, I think, where expert input and multi-stakeholder input comes into play. I don't have a clear answer to that, other than to say that, you know, this measure has perhaps started the discussion.

It hasn't gone far enough, and I

guess the question is, is it reasonable to keep it with clear indications to the developers of what needs to happen in this measure. It looks like Erin has her hand up. Perhaps they do have some plans to --

CO-CHAIR CASEY: Yes. Let me just, for the committee, I see three cards up. Are you still intending to comment, Kathleen? Okay. So let's have one final comment from the measure developers, and then let's move ahead and vote.

DR. GIOVANNETTI: I fully appreciate the committee's comments on how this measure has not come very far. I will place it in the policy context of the past five years with CMS being one of the major funders of measure development. With the death panel comments, CMS stopped anything that had anything to do with advanced care planning.

They removed all the measures from their sets that said anything about advanced care planning. So part of that, I'm hoping,

will be now that we've gotten past that, we will start to see a more friendly policy environment towards the development of these measures. But that explains partially why this hasn't come very far.

CO-CHAIR CASEY: Okay, thank you, thank you. So are we ready to vote? Eva, do you have your thing? Hopefully it will be clear to you now this works, but be sure you point at Nicole. So are we ready, Nicole?

MS. McELVEEN: And Julie, I have your clicker here. So when you tell us your ratings, I will register your vote as well. Okay. So let's get started. Again, we're voting on the subcriteria for importance first, and the first of that is impact.

The four voting options are shown on the screen. 1 for high, 2 for moderate, 3 for low and 4 for insufficient, and you may begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: And Julie, what is

your response on impact?

MEMBER LEWIS: Do you want me -- would it be easier -- do you want me to just send an email rather than having to --

CO-CHAIR CASEY: No. Just let us know the number, like we did with Eva. It will just help us tally.

MEMBER LEWIS: Do you want me to verbally let you know the number or --

CO-CHAIR CASEY: Yes, please. Yes, just tell us.

MEMBER LEWIS: High, 1.

MS. McELVEEN: Okay, we have 23 for high, 3 for moderate, and no votes for low or insufficient. The next criteria is going to be performance gap. You have the same voting options, 1 for high, 2 for moderate, 3 for low and 4 insufficient, and you can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: And Julie, whenever you're ready, just let us know what your vote is for performance gap.

MEMBER LEWIS: One.

MS. McELVEEN: Okay. We have 20 high, 4 moderate, no votes for low and 2 for insufficient. Next is going to be evidence.

CO-CHAIR CASEY: Now we're going to test our new algorithm, right Nicole? We're changing it slightly.

MS. McELVEEN: Yes, correct.

CO-CHAIR CASEY: So pay attention here. There are now three votes.

MS. McELVEEN: There are now --

CO-CHAIR CASEY: If the third vote is the predominant one, then we move into the alternative vote. Does that make sense to everyone? Do you understand that? Okay. So let's test this out.

MS. McELVEEN: So we now have three options for voting on evidence, one for yes, two for no, three, insufficient evidence, and you may begin your votes.

MEMBER LEWIS: One for me.

[COMMITTEE VOTING.]

MS. McELVEEN: We're waiting two, okay, one more person. There we go. Okay. We have 15 for yes, 4 for no and 7 for insufficient evidence.

CO-CHAIR CASEY: So I think that just means we move ahead, right?

MS. McELVEEN: Yes, correct.

CO-CHAIR CASEY: Everyone okay with that? Okay.

MS. McELVEEN: Next will be our second criteria, scientific acceptability of the measure properties. The first is reliability. You have the same four voting options, 1 for high, 2 for moderate, 3 for low and 4, insufficient evidence. You can begin your votes.

[COMMITTEE VOTING.]

MEMBER LEWIS: 2 for me.

CO-CHAIR CASEY: Thank you.

(Off mic comment.)

MS. McELVEEN: I think that means your battery may be low.

CO-CHAIR CASEY: Your balance is low.

(Laughter.)

MS. McELVEEN: Okay. We have 6 for high, 11 for moderate, 5 for low and 4 insufficient.

CO-CHAIR CASEY: Did we get Julie's? We got Julie's.

MS. McELVEEN: Yes, we did get Julie's.

CO-CHAIR CASEY: Okay, great.

MS. McELVEEN: I'm just waiting to switch out his batteries. It was fine. Okay. The next criteria we're voting on is validity. You have the same voting options, the four voting options as shown on the screen, and you can begin your vote.

[COMMITTEE VOTING.]

MEMBER LEWIS: Two for me.

MS. McELVEEN: Two votes for high, 11 for moderate, 7 for low and 6 insufficient evidence. So we will -- the measure will pass

on scientific acceptability of the measure properties.

CO-CHAIR CASEY: It's 13 to 13.

MS. McELVEEN: 13 to 13, it automatically goes in --

CO-CHAIR CASEY: Show those results again.

(Off mic comments.)

CO-CHAIR CASEY: Reliability and then --

DR. BURSTIN: So you have to have at least moderate validity to move forward, and that measure had at least moderate validity. Thank you, yes.

MS. McELVEEN: Sure.

DR. BURSTIN: Yes.

MS. McELVEEN: Hold on. This is validity.

CO-CHAIR CASEY: So that's 7 low, 6 insufficient, 11 moderate and 2 high. So it's 13 for the first two and 13 for the second two.

(Simultaneous speaking.)

DR. ANTMAN: Excuse me. I don't think that included Julie's moderate though.

MS. McELVEEN: We did.

CO-CHAIR CASEY: We did.

(Off mic comment.)

DR. ANTMAN: Okay, thank you.

DR. BURSTIN: I would suggest you just finish the evaluation --

CO-CHAIR CASEY: Okay. Well let's keep going.

MS. McELVEEN: Okay. The next criteria is usability, and you have your four voting options, as shown on the screen. You can begin your vote.

[COMMITTEE VOTING.]

MEMBER LEWIS: Three. Excuse me, 3 for me.

MS. McELVEEN: Okay. 4 votes for high, 14 for moderate, 8 low and no votes for insufficient. Next is feasibility, and you have the same voting options as shown. You

can begin your vote.

[COMMITTEE VOTING.]

MEMBER LEWIS: 3 for me.

MS. McELVEEN: We're awaiting three more, okay. Two more responses. We're awaiting one more response, just to make sure. I hope that's not a tie breaker. Oh, there we go. I did click Julie's. We got it, great.

We have 2 for high, 12 for moderate, 10 low and 2 insufficient information. Yes. It's pretty close. Okay, so the last is overall suitability for endorsement, and the options are 1 for yes, 2 for no, and you may begin voting.

[COMMITTEE VOTING.]

MEMBER LEWIS: One for me.

MS. McELVEEN: All right. Grand tally, okay. 18 for yes and 8 for no.

CO-CHAIR CASEY: So the measure passes. Any questions? I know there was one where it was close, but the committee's

comfortable with the decision. So I think we'll move ahead.

MEMBER McNABNEY: This is just a comment, and we were just chatting. I think it would be -- believe it or not, I think if she voted at the end, I think that people who are on the fence, she's -- we believe her and trust her. So she could be swaying votes, I think.

(Laughter.)

MEMBER LEWIS: Actually, I'm fine with that. Just tell me when it's over, when --

CO-CHAIR CASEY: Well, I think for process, we'll keep it continuous. I'm actually spying on people, because I'm watching what number they're pressing. So I could argue the same thing. So let's keep it the way it is for now. I'm serious. I'm spying on you.

DR. BURSTIN: And in terms of the report, we'll specifically note that there was

a tie on validity and raise the specific issues, and hopefully we'll get comment on that, and I suspect that the developers might be able to provide additional information to help support some of the validity concerns raised today.

CO-CHAIR CASEY: I suspect they appreciate all the feedback that we've given them, so --

MEMBER GREENBERG: Can I just ask a quick question? It's interesting.

CO-CHAIR CASEY: Yes.

MEMBER GREENBERG: My understanding is if I vote say low on impact, reliability and validity, I'm sort of killing the measure. But clearly people are voting low on these things but then passing it. I guess at the individual level, that's fine. It's more at the group level that those rules apply?

DR. BURSTIN: Right, right. So it's more at the group level. It's intended to be a hierarchy. The committee can't move beyond

importance if that fails. The committee can't move beyond scientific acceptability if that fails.

But then at the end of the day, the final assessment is really about do you believe your gestalt of how you individually weigh the criteria, whether the measure should move forward. But again, this is, as Don and Gerri know, who have been around these parts for a long time, this is a very significant change for NQF.

So we are trying, there are definitely some things we're learning along the way, like making sure we add insufficient, like we just did last night, and that will now be in all the slides going forward. But it is a whole lot better than just getting a gestalt of importance and having no idea what it was about importance that was the hang-up.

I think it gives more information to developers and a lot more information to commenters and others.

CO-CHAIR CASEY: Well, and it gives us a real better structure about how to make decisions, which has ultimately been the challenge. So with that in mind, it is quarter to ten. I think we want to keep moving here. I think in the interest of time, the bio breaks can occur on your own for the time being.

I know we will try to take a break at the end of this, but we are -- we're a little bit behind. We're going to move into the med rec reconciliation measures, and I want people to get lined up. I also want you to harken back to some of the discussions we had yesterday, so that we don't spend a lot of time bringing up the points we made about the process of med rec.

I think again, highlighting the insights we gained in terms of the specific measures will be important here. But let's try not to go back on old stuff. Just highlight recalling that we discussed it, but

let's move ahead. So the next measure on my list is, forgive me.

MS. DORIAN: 0097.

CO-CHAIR CASEY: 0097, and that's Jann. So Jann, do you want to lead us off?

Measure 0097

MEMBER DORMAN: Yes. So I will just state that I was not able to be present during the prep call, so if anyone who did participate in those conversations has additional comments, please jump in.

So a brief description of the measure. It is the percentage of patients, age 65 years and older, discharged from any inpatient facility, skilled nursing, rehab, etcetera, and seen within 60 days following discharge in the office by the physician providing ongoing care, who had a reconciliation of the discharged medications with the current medication list in the medical record documented.

So it's a very complex measure, and

I'll just say in advance that the assessment by the group that looked at this, the impressions were mixed throughout the criteria. There was general agreement that the impact was high, and that the performance gap was high.

However, when looking at the evidence, the impressions of the quantity, quality and consistency of the evidence supporting the measure were mixed, medium to low.

In terms of the scientific validity for the measure, there was good agreement that the reliability was high, but I can imagine the discussion. There was feelings that the validity was mixed between high and medium.

For the usability, based on the comments I'm seeing documented, there must have been a great discussion, and again, the usability was mixed between high and medium. It's a fairly complex measure.

Same is true for the feasibility.

Overall, the preliminary assessment, the group felt that -- most people in the group felt that the measure was suitable for endorsement. So do any folks who actually participated in the conversation have additional comments?

CO-CHAIR CASEY: Thank you, Jann. Any additional inputs from the group? Pam.

MEMBER FOSTER: Yes, I was on the call, and I think a lot of our concerns did center around the evidence. The literature that was cited was rather limited. But we did have a fairly strong conversation about just the importance of the measure, just from the gestalt, as you said as a practitioner and professional skill and experience. I think that the consensus was that that outweighed the lack of evidence.

CO-CHAIR CASEY: Chris.

MEMBER KLOTZ: I was also on this call. We did have some discussion about the time frame of 60 days, and especially when you consider so many patients could be readmitted

within that 60 days, there was a lot of question about the time frame, and wonder from the measurement developers why that time frame was selected.

CO-CHAIR CASEY: So that's a question to the developers?

MEMBER KLOTZ: Yes, it is.

CO-CHAIR CASEY: Please.

DR. GIOVANNETTI: Sorry. I didn't know if you wanted us to wait for all the questions. The 60-day time frame was chosen because originally, 30 days was proposed. However, the sample size was too small to get an accurate rate at 30 days, and part of this has to do with patients coming --

Because this is reliant on a patient coming in for an outpatient visit, post-discharge, there weren't enough patients coming in for the outpatient visit within 30 days to allow accurate measurement. You will be seeing that there's another measure that we're going to be talking about, which is a

30-day measure, and really these measures are meant to be seen as a group of measures that look at medication reconciliation, shared accountability over a continuum.

So this is kind of the -- we're doing them in reverse. We're looking at the last one, which is that definitely by 60 days, a patient should have discussed the medication with their physician, and the physician should have evaluated all of these medications for appropriateness, considering their long-term chronic conditions. So that's why 60 days is the time on this measure.

CO-CHAIR CASEY: Chris, does that help. Great. Karen.

MEMBER FARRIS: Could we just have NCQA talk about the fact that this is a hybrid measure, and that it's not just dependent on an EMR but the hybrid, and we thought that was positive, but we're moving toward the electronic assessment.

DR. GIOVANNETTI: So NCQA is working

on making an e-Health measure of this, which would use the electronic health record. It's definitely, you know, NQF has a whole separate process for all of their e-Health measures that are coming through, so some of you guys are on that committee.

You will be seeing those measures as they come through. They're just really fresh out of the door. So this measure does look across multiple data sets. This can be done by CPT-II codes. It can be done by medical record abstraction, and it can be done by electronic health record.

CO-CHAIR CASEY: Thank you. Dana -- I'm sorry, Russ, and then Dana and then Will.

MEMBER LEFTWICH: As a sort of HIT footnote, one of the limitations that hopefully will resolve over the next year is that in the standards world, there is no such thing as a reconciled medication list. A medication list is a medication list.

We're actually in the process of

proposing to HL7 that they add a data element or a couple of data elements that says that a medication list is a reconciled list, was reconciled on a certain date by a certain individual.

So that will enable what really is impossible now, because electronically, it's just a medication list.

CO-CHAIR CASEY: So the subtext, Russ, is that the fact that you're working hard on clarifying the specifications means this remains a very highly important measure?

MEMBER LEFTWICH: I would feel so, yes.

CO-CHAIR CASEY: Great, thanks. Helen.

DR. BURSTIN: Just one comment. This measure actually has been retooled by the developer. It's already been retooled by NCQA and PCPI. So it already -- an e-measure of this measure, at least based on the existing measure, is available. I'm not sure if that

detail was stated.

MEMBER LEFTWICH: Right, and the problem is that there's no reconciliation element.

CO-CHAIR CASEY: Dana.

MEMBER ALEXANDER: This is to the measure developer, NCQA, whether for this measure here, as an example in the description of the measure, again awareness of the terminology, a physician to expand that to more current terminology, to include other clinical providers.

CO-CHAIR CASEY: So Dana, that is feedback to the measure developers for future improvement?

MEMBER ALEXANDER: Yes.

CO-CHAIR CASEY: Okay, thank you. Will.

MEMBER FROHNA: I also participated on the call on this, and had a couple of points. One was the linkage. We started with again the linkage of the process measure with

an outcome. Again, I think this is an important step and an important measure, but it's kind of linking to something that ends up being a value.

The second thing is asking if using PQRI as more of the evidence to support this. Back in 2007 and 2008, what were the number again? How many physicians actually participated in or selected to choose this measure?

Then it's kind of interesting. Using PQRI, that your reimbursements. My understanding if you participated in 2010 in the PQRS, you would actually see your dollars coming back in 2011, mid-year. So I'm just kind of wondering how come we're still so handicapped by the 2007-2008 information, and we don't have anything more current to work on?

CO-CHAIR CASEY: NCQA?

DR. GIOVANNETTI: You'll have to excuse me. I'm looking through the form to

find the percent reporting on this measure, and I can get back to you on that. I will let my colleagues at AMA, they were the ones that ran the data for us, discuss the most available data. Yes.

MS. CHRISTENSEN: So the 2008 PQRI data that we have is actually confidential, shared with us simply because we were completely desperate and CMS was very nice. They don't report this data publicly, so it's very difficult to get. We do ask, as do our colleagues on a regular basis, whenever we have the opportunity to discuss it with CMS.

But it's just unfortunately very difficult for them to compile it in a way that they feel comfortable sharing with the public.

CO-CHAIR CASEY: Do you have a gut sense of how much it's used? Eva.

MEMBER POWELL: Let me just ask a question about the targeted provider population. This is explicitly relative to, on the provider level. Is that true? So just

thinking ahead toward meaningful use, which includes this as a criterion for both hospital and physician populations.

So knowing that we're going to need to measure this, we've got the physician population covered. Could this be used also for the hospital population, given that you mentioned that the e-measure looks across multiple data sources. Would that then make it reliable and valid also in the hospital setting, or how would that be done, or is there a different measure for the hospital setting?

DR. GIOVANNETTI: So this is in the PQRS data measurement set, which means these measures are only specified for physicians, because they are intended to inform physicians about their performance. We have, if you look at this measure, in combination with the three other medication measures. The one that you voted on yesterday, that talked about medication reconciliation at the hospital

level, in which a patient was given a reconciled medication list.

This measure, which looks at the physician level, and then the next measure that you will evaluate, which looks at the health plan level, which says a reconciliation occurred at 30 days. It's not specific to hospital or physician. It's just for every patient that was discharged. So they all kind of work together.

CO-CHAIR CASEY: So there are no cards in the air, and that means that we are getting in position here. So let me just ask Julie on the phone, Julie, any comments or questions for you?

MEMBER LEWIS: No, I don't think so, except on hopefully good news, that we got an instant chat set up, so I don't have to verbalize it, for those that were concerned. But I can still send it instantaneously. So we're all ready to go on that.

CO-CHAIR CASEY: Cool. You're

Tweeting you vote, okay, or something like that.

MEMBER LEWIS: Yes, quite right.

CO-CHAIR CASEY: Cool. All right. So everyone get your devices in your hand, and let's move forward with the vote. Are we ready, Nicole?

MS. McELVEEN: Yes.

CO-CHAIR CASEY: Great. James don't leave.

MS. McELVEEN: Okay, everyone is ready. So again, first we're voting on impact, and you have the four voting options on the screen, and you may begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: Okay.

CO-CHAIR CASEY: Did you get your Tweet?

MS. McELVEEN: We did get our Tweet. So we have 19 votes for high, 7 for moderate, and no votes for low or insufficient. Next will be performance gap. You have the same

voting options as shown on the screen. You can begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: And we're awaiting two, one more response. Oh, there we go. 21 votes for high, 4 for moderate, 1 for low and no votes for insufficient. Next is evidence. Again, you have three options for evidence. 1 for yes, 2 for no and 3 for insufficient. You can begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: We're awaiting one more response. 17 yes, 3 no and 6 insufficient.

CO-CHAIR CASEY: So we'll move ahead.

MS. McELVEEN: We will move ahead. The next criteria is reliability, and this is for the scientific acceptability of the measure properties. You have four voting options as shown on the screen. You can begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: We're awaiting one more response. Has everyone voted? I have --

CO-CHAIR LAMB: Would everybody put their number in again, so we can get the last one.

MS. McELVEEN: There we go. We got it, good. We have 7 votes for high, 18 for moderate, 1 for low. No votes for insufficient evidence, and this is again on reliability, just so we're clear.

Next is validity. Again, same four voting options as shown, and you can begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: All right. Three votes for high, 21 for moderate, 2 for low and no votes for insufficient evidence. So we will move forward. The next criteria is usability. Same four voting options as shown on this screen. You can begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: Okay. We have 7 votes for high, 17 for moderate, 2 votes for low and no votes for insufficient information. Next criteria is feasibility. We have the same four voting options. You can begin your vote.

[COMMITTEE VOTING.]

CO-CHAIR CASEY: I don't know how to vote, now that I can't hear Julie.

(Laughter.)

MEMBER LEWIS: I can Tweet you too, Don.

(Laughter.)

CO-CHAIR CASEY: Cool.

MS. McELVEEN: Okay. We have 7 votes for high, 16 for moderate, 3 for low, no votes for insufficient, and lastly, overall suitability for endorsement. 1 for yes, 2 for no. You can begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: 25 vote yes and 1 vote no. So the measure will pass.

CO-CHAIR CASEY: Okay. I think, given that 554 NCQA is the one that's the 30-day that you mentioned, we'll do that one now, so that we sort of hybridize that. So 554 is Karen, and let's move into that. And again, let's try to keep our conversations compact. Obviously, there will be some nuances here, but Karen, lead us off.

Measure 0554

MEMBER FARRIS: So the description of the measure is the percentage of discharges from January 1 through December 1 of the measurement year, for members 66 years of age and older, for whom medications were reconciled on or within 30 days of discharge.

This is health plan level measure. It is not at the provider level. In terms of importance, we had a lengthy discussion about the evidence, which we actually had yesterday as well, when we were talking about med rec at discharge, so I'm not going to rehash that.

But we were a bit divided in terms

of the mixed results and recognizing there's not an RCT that's just going to look at med rec. But there's been several nice studies that have looked at a package of things at discharge.

So I'm going to leave that with you. You can see on our report that importance, we said yes 2, no 6 was our original voting, and I'm hopeful that we've moved past that negativity.

In terms of scientific acceptability, I did want to point out actually a performance gap in the data that are presented. The average percentage was around 32 percent, 34 percent, 33 percent, in getting this done for patients at discharge. So there's definitely room for improvement.

In terms, I just wanted to quickly tell you reliability and validity, so you had a sense of that. The med rec was measured for face validity by two different panels, and that was positive. The average reliability

across 262 health plans was 0.97 for the 2010 measurement year.

The lowest reliability in any health plan was 0.84, so those are strong. The next thing is usability, and this is already reported. This is a HEDIS measure, correct, and so it's already publicly reported. So in terms of feasibility, on our call, that's where we had talked about if you don't have an EMR, can you really do this, and that's where the NCQA told is that it as a hybrid measure.

So depending on what your system was, they could accommodate both of those for now. So I think we felt a little better after that, but other group members can comment when I finish.

Let's see what else did I want to say. So the overall assessment was 5 to 2, and I think that's all I have to say, except that again, we would look at the at-discharge was Measure 646. This was a measure at 30 days for 554, and then specifically the 60-day

measure as at your provider level, which was 0097.

So if we could think about how to put those together in the future, that would be really cool.

CO-CHAIR CASEY: Are there other members of the subgroup that wish add to Karen's elegant summary?

(No response.)

CO-CHAIR CASEY: So discussion. Yes, Eva.

MEMBER POWELL: I just wanted to make a comment along the lines of what Karen just said about kind of aligning these. I think again, looking toward the ideal of the future, but knowing we're not there yet, it would seem to me like there would be a way to look at this group of measures and align them, such that since even though the measures address different levels, in terms of health plan provider, hospital.

Particularly at the health plan

level, it would seem advisable to have the same data used for both measures. I mean it does all come from the provider. So I don't know if that is a "easy fix" for moving forward, that we could require. I just, I'm really concerned about anything that's not aligned, and would have a hard time supporting things that are so disparate.

CO-CHAIR CASEY: So Eva, I think your point is extremely well-taken, and I believe when we get to the discussion that Helen will help us with on competing measures, we'll get into this. I know that's on everyone's mind, given that we have four med rec measures that we're voting on. So Karen, did you want to say something?

MEMBER FARRIS: I wanted to ask NCQA why this measure is 66 and not 65? The previous measure was 65. Can we make them all 65 or 66?

DR. GIOVANNETTI: So this is, has specific things, the HEDIS measures. The

reason that it's 66 at December 31st is that we want to make sure that the patient, over the course of the full year, was Medicare-eligible. So this means that they have to -- at no point during the measurement year were they not eligible for Medicare.

CO-CHAIR CASEY: So it's a technical plan issue. Alonzo.

MEMBER WHITE: We routinely reach out to every member that is discharged from the hospital, and one of the things we ask about is medication reconciliation. So can we actually use health plan data? We don't necessarily depend on what's in the EMR.

CO-CHAIR CASEY: So you're asking NCQA?

MEMBER WHITE: Yes.

CO-CHAIR CASEY: Yes. Did you get that?

DR. GIOVANNETTI: I'm sorry. Could you just repeat the question? This is --

MEMBER WHITE: Okay. The health

plan that I work for, we routinely reach out to every member discharged from the hospital, and ask a question about medication reconciliation, 100 percent that we're aware of.

DR. GIOVANNETTI: So this measure would say that if that discussion has been documented in the medical record, that a provider, be that this one, does include a larger array of providers. So if an RN, a prescribing practitioner or a physician discussed the medication, looked over the medication list and noted it in the medical record and it was documented, you would get credit for this measure at the health plan level for all discharges.

MEMBER WHITE: Okay. But the health plan record won't have the information from the individual practice per se. They would actually have their own separate information. Is that valid, since it's a health plan measure?

DR. GIOVANNETTI: So this is collected. So for our hybrid measures, these are based off of a random sample of medical records, which are abstracted and used to get -- so we don't go through the medical records of every single member in the health plan.

That would be a little bit onerous, but we do take a random sample and that random sample is audited by NCQA to get this rate.

MEMBER WHITE: Okay. So as long as it's in the medical management record that it's happened, then you would count that?

DR. GIOVANNETTI: Yes.

MEMBER WHITE: Could we also provide that from alternative sources, like from a vendor?

DR. GIOVANNETTI: It has to be documented in the medical record of the patient. I think I'm not quite sure where this --

MEMBER WHITE: Okay, okay. The reason, I'm trying to be clear to you. I work

for WellPoint, okay. We have our own medical management records which are separate from the EMR. These are our records that we keep. We reach out to every member that's discharged from the hospital, and we do medication reconciliation, but we do it through a vendor, okay.

What I'm trying to figure out is can we get credit for this, since this is a health plan measure?

CO-CHAIR CASEY: Alonzo, my understanding is that the method they use is chart abstraction. So I think it is what it is.

MEMBER WHITE: But the thing is that there's not always a chart, but it's still done, and are there alternative methods of documentation that you would accept?

CO-CHAIR CASEY: And --

MR. REHM: Maybe I can help clarify. If I understand, Anthem's approach is that it's asking the patients if this has been

done; is that right?

MEMBER WHITE: That's correct.

MR. REHM: Okay. So this is a patient self-report mechanism, if I'm hearing you. And you know, just as a corollary, in our disease management accreditation programs, we have a variety of mechanisms so that patients can self-report through a live interaction with a clinician on the other end, and validate those sorts of things, and those are -- that's amenable for that particular program.

For health plan HEDIS measures, that patient self-report is not part of the way the measure is specified.

MEMBER WHITE: Okay.

MR. REHM: And in the same way that -- other biometrics are not. We generally are very wary. The evidence is fairly weak on accuracy of patient self-reporting in a variety of mechanisms, some strong, some weak. But essentially that's a different arena.

MEMBER WHITE: Okay. Next level down. If the nurse and RN actually does go through the medications with a member, and does have information from the hospital, does that count, as a part of her assessment?

DR. GIOVANNETTI: If it is documented in the patient's medical record, yes.

MEMBER WHITE: That's not what I'm asking, because on every encounter that we have, when one of our nurses reaches out, we always do medication reconciliation 100 percent with everybody, and that's a nurse going through the record. That does not count, because we have our own set of medical management documentation that's separate from the EMR.

DR. BARTON: So I think that NCQA's goal in having this measure is for health plans to document that they have taken care of patients within 30 days of discharge, and I have to say, as a primary care clinician, my

concern is the crazy medications that patients get put on in the hospital, that they need to be taken off of.

So that's why I don't think that a phone call from your health plan doesn't actually take you off the duplicative medication that you were put on in the hospital. You need a prescribing clinician to do that. It could be a nurse, and then if there's close communication with a primary care, sort of function. But that's the purpose.

It's not just to say I see what you were discharged on, it is to say I see what you were discharged on and this is how that interacts with what you went in on, and this is the final set that I think you should be on going forward from now.

CO-CHAIR CASEY: So I want to jump in here and say it sounds like Alonzo, it is a technical issues that is fed back to NCQA and that is a nuance that is important to the plan

that is not, I think accurately spelled out in detail in this measure set. So I think we're just going to have to call it what it is.

But I do appreciate what you're saying back to them as being important in terms of strengthening this type of measure in the future. So I'm going to ask Anne-Marie.

MEMBER AUDET: Yeah. This may be on the wrong side, and I apologize. In your exclusions, you exclude readmissions, and I just wonder whether you're missing -- some of the reasons for the remission may have been that there was no reconciliation.

Now I understand this is a 30-day period so it's a complicated issue of timing. But I just want to hear your thought about excluding readmissions, and the impact it might have in obscuring maybe one of the causes of readmission being --

DR. GIOVANNETTI: So we definitely agree with you, that the important thing is to understand that the denominator of this

measure is not based on patients; it's based on discharges. So the reason we exclude the readmissions is that we don't want to double ding somebody by -- so they're still going to be in the denominator for this measure, but they just won't be in the denominator twice off of that.

This was something that the committee, looking over this measure, debated a lot, but decided that it was -- as you can see, it's hard enough for a lot of these plans to get this done when you exclude readmissions, so we don't want to be too hard on the health plans in terms of really racking up their denominators.

So it's not to say that if you will have a readmission you are excluded from this measure. It's that the first discharge is not included in the denominator but the second discharge is.

CO-CHAIR CASEY: Anne-Marie, does that clarify it? Eva.

MEMBER POWELL: Thanks. I just wanted to speak to Alonzo's point, because I can appreciate the fact that their process is aimed at taking care of patients and doing right by them post-discharge. I think what my concern would be in terms of the measure developer looking at this and trying to accommodate that is that this measure ultimately is a care coordination measure, and therefore the point is not so much for the plan to get credit for doing right by the patient; it's for the patient's care needs to be met longitudinally.

So if the documentation of the medication reconciliation is in their internal records, it is not useful toward the ultimate purpose. So I guess my comment is one that yes, we need to accommodate various processes, but we need to also make sure that those processes are meeting the ultimate goal, and having an internal record is not at all meeting the ultimate goal of coordinating care

across time and providers.

So I just wanted to put that observation out there, that would be of concern in that situation.

CO-CHAIR CASEY: Thank you. Karen. Karen, are you -- oh, okay. So Jeff.

MEMBER GREENBERG: I just wanted to add briefly that I kind of liked this one more than the last one because of the medical record abstraction part, just getting at the validity issue of the coding, which is still a sticking point for me.

You know, I like that you can actually look through records and actually do sampling, and find out if it was actually done, rather than hoping that the coding reflects that.

CO-CHAIR CASEY: So with that, we are, I think, Nicole ready to go. So are you ready?

MS. McELVEEN: I'm ready.

CO-CHAIR CASEY: And Julie are you

ready?

MEMBER LEWIS: Ready.

MS. McELVEEN: So under importance to measure and report, the first criteria is impact, and you can see the four voting options as shown on the screen, and you can begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: One more response on impact. Has everyone voted?

CO-CHAIR CASEY: Press again, just so we --

MS. McELVEEN: There we go. So 20 high and 6 moderate, and no votes for low or insufficient. The next is performance gap. You have again the same four voting options and you can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 15 high, 11 moderate, and no votes for low or insufficient. Next is evidence. Again, you have three for evidence. 1 for yes, 2 for no and 3 for insufficient.

You can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: We're awaiting one more response. Everyone can just make sure -- yeah, okay, we got it. 20 yes, 4 no and 2 insufficient. So we will pass on importance and move on.

The next is going to be the scientific acceptability of the measure properties and reliability vote. You have the same four voting options, and you can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: All right. 9 for high, 15 for moderate and 2 votes for low. None for insufficient evidence. Next is validity. The same four voting options as shown on the screen. You can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 6 votes for high, 18 for moderate and 2 votes for low. No votes for insufficient. So the measure will pass on

the scientific acceptability of the measure properties.

Next is going to be usability. Same four voting options as shown. You can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: One more response on usability. There we go. 9 votes for high, 16 for moderate and 1 for low. No votes for insufficient information.

Next criteria is feasibility. Four voting options as shown on the screen. You can begin. Excuse me. Okay. We can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 6 votes for high, 16 for moderate, 3 for low and one for insufficient information. Last is overall suitability for endorsement. 1 for yes, 2 for no. You can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 25 votes for yes and

1 vote for no.

CO-CHAIR CASEY: Okay, good work. We still have two more measures to go, but I think we should take about a 13 minute break. So let's come back at 20 of 11:00 and try to finish up the last two, so we can move into the rest of the agenda.

(Whereupon, the above-entitled matter went off the record at 10:30 a.m. and resumed at 10:43 a.m.)

Measure 0553

CO-CHAIR CASEY: The next measure we're going to discuss is 0553, and I have Lorna. Lorna, are you in position for this? Attention. Hey Lauralei, would you like to get those guests? Get them moving.

If we could come to order please? Lorna, why don't you kick us off?

MEMBER LYNN: Okay. So this, I believe, is our last med rec measure.

CO-CHAIR CASEY: Yes.

MEMBER LYNN: So there may be some

nostalgia in the room. This measure is different. The description of this measure is percentage of adults 66 and older who have had a medication review, a review of all members' medications including prescription meds, over-the-counter meds and herbal or supplemental therapy done by a prescribing practitioner or a clinical pharmacist.

The numerator requires that not only this med review be done, but that a medication list be in the medical record. So where this is different from the other measures we've looked at is that there is no transition event required to trigger this. This is for all patients 66 and older, and I think the 66 is for the same reason as the last measure.

There are no exclusions specified in the denominator, and an outpatient visit is also not required. So something that I'd like the developers to comment on after I'm done is there was also a statement that health plans could have optional exclusions for this. So

I was little confused as to no exclusions and optional exclusions being possible.

I'm not going to into much about the importance to measure, because this is the same as we've heard for the last several measures.

There was some nice data provided by the developer from 2008 through 2010 on a sample of about 300 patients that showed performance, mean performance across the sample, starting at 58 percent and increasing to 65 percent.

So I think they are showing us that there still is a performance gap, although it is looking like it's getting a little bit smaller. In terms of our discussion about scientific acceptability, there was some concern when we spoke on the phone call about a lack of specificity as to what a medication review was.

This is a measure which is reported through claims. The claims are based on

what's in the medical record. So I think that's why the data sources are listed as administrative claims, paper or electronic health records, and I believe that NCQA is working on an e-measure for this that's not yet complete.

In terms of the scientific acceptability and the reliability testing, they did a beta binomial analysis, which I won't begin to pretend I could explain. Their face validity testing, in their initial application that we saw in our phone call, they just said this had been done.

They provided us some updated information that gave a lot of detail on the face validity testing, which included two different expert committees that have gone through a step-wise approach to looking at the elements.

They also included a statement on disparities, that they are not -- this measure is not specified to look at disparities, but

they agree with the IOM statement on how important it would be to look at that when it is possible by health plans, but they're not requiring this in the specification, so they don't want to add to the burden and decrease the feasibility.

The data sources listed -- I'm sorry, the level of analysis was a little confusing to me. I know this is a HEDIS measure and it's reported at the health plan level, but it's also listed as being something that can be reported for individual or group practices. So maybe if you all could clarify that, that would be helpful.

CO-CHAIR CASEY: And Alonzo, would it be fair to assume that the issues you had with the previous measure could potentially in some regard apply to this one?

MEMBER WHITE: Yeah. I had the same concerns about one, discounting the role of the health plan. The second is how are you going to collect the data without doing chart

abstraction.

You might have access to some information that's in the medical home, an ACO-type program where you're sharing data. Otherwise, you're going to have to use chart abstraction.

CO-CHAIR CASEY: So that feedback applies to this measure as well. Other comments from those in the initial preliminary group? Gerri.

CO-CHAIR LAMB: Two things. One, going back to what Lorna was saying, is I'd like to hear some discussion about what a medication review is, and whether it's simply a checkbox, that I say I did it; therefore, I did it, however it comes across.

And the other thing is just a comment, and maybe this is just a precursor to the discussion later, is the whole idea of care coordination and the handshake that we've been talking about. What I'm beginning to get some insight into is the set of measures that

maybe what's necessary to move into care coordination, but not are care coordination, and this is one of them.

And so I think that's more of a conceptual discussion later, but I don't see this as a primary care coordination measure.

MEMBER LYNN: Can I just say that is -- I thought more about this. I think it does represent care coordination, because it is the opportunity that the clinician takes, to see what's going on in the whole realm of what care is being provided to that patient, to have the opportunity to learn about medications, over-the-counter medications that may have been prescribed elsewhere. So it's a bit of a reach, but I do look at it that way.

CO-CHAIR LAMB: I think that's very reasonable Lorna, and it goes back to then the specification of the numerator, what is this and is it a checkbox?

CO-CHAIR CASEY: Kathleen.

MEMBER ALLER: I'm just looking for

clarification from NCQA. Is this in fact reported the same way as the previous measure? In other words, it's 100 percent a matter of you doing random chart reviews for the health plan?

DR. GIOVANNETTI: Yes, that's correct. This is --

CO-CHAIR CASEY: So excuse me just a minute. Any other -- I want to package these up for you, so you can do them all at once. Any other questions for NCQA?

(No response.)

CO-CHAIR CASEY: All right. Can you address these questions?

DR. GIOVANNETTI: Okay. I hope I got them all down. So yes, this is exactly the same method that was used for medication reconciliation. It's what we call a hybrid measure. It can be collected through administrative data, which would be CPT-II codes. It could also be collected through medical record, which is a random sample of

medication record abstraction.

It can also be collected through electronic health record data, where that is available. All measures are audited by NCQA, so when we look at the medical record, what we're looking for is actual -- we look not just for did the medication list go in there, but documentation that the physician had or the prescribing practitioner had a discussion with the patient about their medications, and viewed those medications for continued appropriateness.

So once again, you know, getting at really the quality of this discussion is very difficult when you're talking about something on a health plan level, and at the moment, this is how the best we can do it, given as not everybody has electronic health records yet. So we do this through the medical record review.

In terms of the exclusions, that was a mistake on the form. I apologize. There

are no exclusions to this measure, so just to clarify. The reason that an outpatient visit is not required for this measure is one, we want to be inclusive of telehealth and other options for a prescribing practitioner to discuss this issue with the patient.

And also, just because a plan isn't getting their patients to come in for outpatient visits, doesn't mean they aren't still responsible for having this occur. Let me see if there was anything else.

In terms of, to get to Alonzo's comment, this really needs to be something that is done with the patient's provider. So even though at the health plan level this may be being done, it needs to be communicated down to the individual's provider level, and it needs to be a discussion between the patient and their provider.

CO-CHAIR CASEY: And I would paraphrase Alonzo as saying that they feel as though they have services that are actually

providing care to the patient. So I hope I'm saying that correctly, without getting into a --

MEMBER WHITE: And let me point out one other thing, other than what you just said. We also have the pharmacy claims data. That often tells us more than what's in the doctor's record. Because we know if they're filling their prescriptions; the doctor doesn't.

CO-CHAIR CASEY: So I think you're getting into some very important technical details about where we need to end up, which is it's one thing to receive a prescription; it's another thing for people to understand it.

It's a third thing for them to get the prescription, and then finally it's most importantly whether they're following the recommendations by taking the medicine, and are there adverse side effects occurring.

So again, this whole medication

administration process is not something that we have our eye on the prize for yet. But I think you're starting to get at some of the parts of it. Jeffrey, and then Emilio.

MEMBER GREENBERG: I just wanted to ask how the medical record abstraction part of this worked. If I wanted to report on this measure, I would -- is there some form I would use to do the record abstraction and document that. This was done in X percent of cases or something, or there's a --

DR. GIOVANNETTI: I'm going to let Bob Rehm talk about that.

MR. REHM: I'm sorry. I was thinking about the previous question.

MEMBER GREENBERG: Oh yeah. I'm just trying to figure out how the -- I mean the med record abstraction would work. Who does it, how do they do it?

MR. REHM: Okay. So just to explain the hybrid method, because it leads into that. A health plan would look for an

administrative, essentially an administrative net, which would either be a regular CPT code, which is referenced here, or a CPT-II code. So either/or that identifies that service.

If they don't get a numerator hit on that, then they would then go to the medical record, the health plan would. Then the health plan performs, it basically sends out nurses into the field generally, and it sets up appointments with physicians' offices, and it says here are the 15 people on the panel we need to see on a variety of measure sets, and it looks in the medical record and it documents that that happened.

So then that becomes a medical record numerator hit, to use the expression. So you add the administrative numerators and the medical record numerators together, and that becomes the composite numerator.

MEMBER GREENBERG: So is NCQA nurse that goes out?

MR. REHM: No, no. This is the health plan.

MEMBER GREENBERG: Oh, the health plan nurse.

MR. REHM: The health plan nurse, and they have sophisticated programs and they take their laptops out, and some plans are -- I mean I know WellPoint has a fairly effective, do this electronically.

But then if one of the -- all those things are audited then by, you know, certified auditors that are in the business of making sure what just happened, that the health plan accurately captured what was going on in the medical record. So that's the whole cycle. Jeremy is there anything to add to that.

MR. GOTTLICH: Just that the certified auditors go over these abstractions. That's part of their audit process.

CO-CHAIR CASEY: Is that good, Jeff?

Lorna?

MEMBER LYNN: Could you comment on the level of analysis? Is this just health plan?

DR. GIOVANNETTI: Yes. I apologize. That's the one -- I knew I was forgetting one. We specified this measure at the health plan level, and this is common across all of our measures, that often plans will use this information to determine clinician or individual practice level performance.

That's what plans do with this information once they get it. So yes, it's being used on different levels. We only specify this on the plan level. So this really comes down into NQF and which box do you want us to check. It's specified for the health plan level, but it's being used on multiple levels.

CO-CHAIR CASEY: I just have one editorial suggestion here, and that is that medication review is again not something that,

as a heading is not well-specified or understood. I clearly see the intention and I know the physician who made a comment before, explained that.

So I'm not asking you to comment; I'm just asking you to perhaps help us to be sure that the end users understand what is meant by that explicitly.

So nothing to do with our vote. Just an enhancement to being more precise. These comments have been across the board, so they're not just germane to NCQA, that we're using terminology that I think sometimes gets out into the field, and then is all over the map.

So just precision about what you mean by that. Even if this is in the standardized definition, at least clarify what those components are. So I think everyone around the table would agree with me. So Julie, are you with us?

MEMBER LEWIS: I'm here. I'm good,

thank you.

CO-CHAIR CASEY: You're good. So no cards are up, Nicole, so that means you're on.

MS. McELVEEN: Okay. So everybody is ready for voting. Let's begin under importance. We're voting first on impact, and you have your four voting options shown on the screen, and you can begin your vote.

[COMMITTEE VOTING.]

MS. McELVEEN: We're awaiting one more response. Okay. We have 19 votes for high, 7 votes moderate, and no votes for low or insufficient.

Next is going to be performance gap. You have your four voting options shown, and you can begin votes.

[COMMITTEE VOTING.]

MS. McELVEEN: Okay. 14 votes for high and 12 votes for moderate. No votes for low or insufficient. Next is on evidence. Again, you have three voting options, 1 for yes, 2 for no and 3 for insufficient evidence.

You can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 18 yes, 5 no and 3 insufficient evidence. So the measure will pass on importance, and we're moving on to the second major criteria, scientific acceptability of the measure properties. First voting on reliability. You have four voting options as shown on the screen, and you can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 9 votes for high, 14 for moderate, 2 for low and 1 insufficient evidence. Next is validity. Again, same four voting options, and you can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 5 votes for high, 17 for moderate, 2 for low and 2 for insufficient evidence. So the measure will pass on scientific acceptability. The next criteria is usability. Four voting options as shown on the screen, and you can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: And we're awaiting one more response on this. 7 votes for high, 17 for moderate, 2 votes for low and no votes for insufficient.

Next criteria is feasibility. Four voting options shown on the screen, and you can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 3 votes for high, 19 for moderate, 4 votes for low and no votes for insufficient information.

Lastly is overall suitability for endorsement. 1 for yes, 2 for no. You can begin voting.

[COMMITTEE VOTING.]

MS. McELVEEN: 25 votes for yes, 1 for no, so the measure will pass.

CO-CHAIR CASEY: So I guess the correct 2012 slang term for what we just did was that that was the bomb, okay. So that's what I understand as being wicked good, I

guess.

(Simultaneous speaking.)

CO-CHAIR CASEY: There we go. Just trying to be cool, which is very 20th century to say. All right. So we have one more, but this is going to be nuanced, because this is going to be a different sort of discussion and set of sort of points of view that we're going to have to innovate on and perhaps maybe improvise on.

But this relates to the last measure, which is the medical home survey, 0494, and I know Emilio, you're set up. But before we do that, I think what we wanted staff to do, with the help of Karen Johnson, Helen and Karen Pace, is to just give you a review of the criteria for evaluation for what we're calling composite measures.

I don't think we have specific language on survey scores. So we're kind of potentially grouping this into the NQF category of composite measures. So Karen, do

you want to run through just a reminder of how this has worked in the past?

Measure 0494

MS. JOHNSON: Yes. What I'll do here is just show you some of our criteria for the composite measure, which is a little bit different than what were called single measures that you've already looked at, and I'll just ask Helen to jump in if I say something wrong. She'll fix it for us.

So, first of all, the composite measure is really made up of what we call components. So the measure that you'll be looking at next has six components in it. So what we're going to ask you to do is look at the individual components, and what you want them to be is either already NQF-endorsed, or meet measure evaluation criteria as our first step.

So basically you're applying the same criteria that you applied to the single measure to the components. All right. So for

importance to measure and report it is a little different, because a component measure itself may not be important on its own necessarily, but it might be important enough to be wrapped up in the composite measure.

So there is a little bit of weighing on this. But you do at least want to think about importance, and the impact gap and evidence criteria, okay? Does that make sense? Hopefully it does.

You also want the component measures to be consistent with the conceptual construct, okay? So in this case, our conceptual construct is the health home. So each of those components ought to fit in with that concept. And I think some of this will become clearer as you see this, hopefully.

For scientific acceptability, things that you're looking at will be again for each of the components, things like what are the scoring rules, weighting rules, how missing data and sample size are handled, that sort of

thing.

Again, you're thinking about testing reliability and validity. You're thinking about meaningful differences, basically the same threats to reliability that you thought about before.

I think I already said this. The components need to fit the conceptual construct, and also we would hope that the component analysis that the developers do would show you how each component contributes to the overall variation.

We also want the scoring and weighting rules to be consistent with the concept, and hopefully they would have talked about missing -- anything that's missing. Usability and feasability, you want enough detail so that you can deconstruct the composite measure itself, and you want to know that the measure achieves the stated purpose, in this case health home, and feasibility is basically the same thing as for the single

measures that you've already done.

I think that's the slides for this measure. Going back, we do have to admit a little culpability on this measure, because there were a couple of things that we should have asked NCQA to tell us about, and it was not apparently on our form.

So if you'll bear with me just a second, I think the first thing I'll do is ask NCQA if they can respond to this. You may or may not be able to -- because we're hitting you with this. You might not have seen this before.

But we would like to know, for your component analysis, can you justify their inclusion in the composite measure? Okay? So do you have analysis to justify those inclusions, in this case the six components?

Do you have analysis that would tell us about how each of those components contributed to the variability of the whole, the composite score. And then finally, do you

have analysis to support the differential weighting of the components in the score?

And you probably want to go ahead, if you can, and respond to those now, and then we'll open it up.

DR. BURSTIN: And just one more thought, since not everybody got to hear the description, I think, because this is such a complex measure. Perhaps while you're answering those, a little bit of description up front, just a few minutes on the composite itself, I think, would be useful for the committee.

CO-CHAIR CASEY: Why don't we have Emilio and the subcommittee go through their analysis and then we'll come back to NCQA, just so we can get the feedback from our experts.

MEMBER CARRILLO: Sure. I think that our analysis will just get the ball rolling, and they'll come in with more definitive information. But again, this is a

case where the measure development information came in towards the end.

So, in fact, only two of us, myself and Tom Howe, had a chance to review it and to actually respond to the -- as we have to the various different pertinent components. This is an aggregate measure of the quality of ambulatory care, and it includes six key components of ambulatory care.

Now where do these come from? This is not something that just came -- came about recently. Basically, the discussion about enhancing primary care goes back to the late 60's-early 70's, in both the professional societies for family medicine and pediatrics, and also internal medicine, have weighed in over the years in developing a set of criteria that, based on expert panels and based on the expertise of professional societies, came and evolved over the years.

In 2007, there was a joint statement put out by the professional societies, that

basically articulated these components that we're now talking about, these six components. And also CMS came in and took a look at this, and adopted the analysis the joint group of professional societies.

What are these six buckets? Access and continuity of care, identification and management of the patient population, the plan and managing the care of the patient, the care plan and managing the care of the patient, providing self-care support and community resources, tracking and coordinating the care, and measuring and improving in performance.

I should add that the Wagner Chronic Care Model also has informed the articulation of these various components that we have before us now. And in fact, the six components make up -- are made up by 27 elements, each of which includes a number of factors.

The impact -- I think it's very substantive, given that the concept of the

patient-centered medical home is wrapped up in health care reform, not just in the federal government but also in many states, particularly in New York we're quite familiar with it.

It aligns with meaningful use, and this particular -- the 2011 iteration of these measures is particularly meant to align with the meaningful use standards.

And lo and behold, in terms of us, these measures align very nicely with the preferred measures -- the preferred practices 1 through 5. So there's alignment and meaning wrapped up with these measures at a number of different levels.

So, secondly, in terms of performance gap, the group has done some analysis, and they have described how each of the six components reveals performance gaps. Now that's a more qualitative review. They have drilled down at looking at all the measures, and looked at 1,400 cases over four

years, and they were able to demonstrate this performance gap.

And, again, in the qualitative review, they looked primarily at the HIT, the use of information technology, the delivery of chronic care, and the care transitions. So some attention was paid to that by the evaluators.

In terms of evidence, they did a nice job in terms of looking at the literature, and they have 16 studies that are cited. Again, a lot of this builds on the evidence of the Wagner model, which has been going around for the last ten years, and there is quite a bit of evidence supporting many aspects of that.

The quality -- I think the studies are not RCTs. They are good quality, and they are consistent, although directionally -- although in terms of the exact quantitation, there is of course differences.

In terms of reliability, they

conducted testing. They have a random sample of 422 patients of the medical homes, that they looked at the agreement between the self-report -- because there was a self-reporting that's done by the practices -- and the actual evidence, the backup evidence to review, to see that there is concordance. There are -- you know, they do find that it's quite consistent.

In terms of validity, again, as we have in other measures, we're dealing with an expert panel that has provided the intelligence on this. In terms of usability, I think usability is very high. I mean, right now this is something that the state of New York, for example, is using these measures, which break down into three levels, adding up the score on all those different yes-no answers, into a Level 3, 2 and 1, and there is enhancements to the Medicaid reimbursement that support the level of the scoring that you get on this particular measures.

My own particular biggest concern with this aggregate measure is the feasibility. It's hard. I mean, putting together -- for practice to put together an application and go through the scoring system is very hard.

The NCQA is very helpful. They have people that are -- get on the phone and work with you, and some states provide support, and some academic medical centers, like my own, provide support to physician practices. But in terms of feasibility, I think that there is some concern.

So, again, I can't give you the scoring, because it was just Tom and myself. Maybe Tom, you want to just mention your own perspective on this?

MEMBER HOWE: Yes, I don't have a lot to add to Emilio's comments, in terms of the scientific base and the validity. It is a difficult instrument to use, and I agree entirely with his feasibility statement.

I think, though, that we have also -- the document itself is huge, but then behind it there's a great deal of supporting information, which I think is pertinent and we probably do want to review, namely the 2011 specifications, which get into the composite scoring, which I think can give some of the folks here more comfort that we're actually dealing with a scientific base here of measures down to the numerator's and denominator's specifications and how they're scored and weighted. I guess we'll review that.

But I agree with Emilio that this, while it's a cumbersome measure and ideally it probably would be better addressed in its components, I think that the direction -- and this is probably the best measure that we've been reviewing in terms of actually getting at coordination of care.

So I think if we can see our way to working with its peculiarities, that I would

support this measure.

CO-CHAIR CASEY: Jeff.

MEMBER GREENBERG: So I'll state my bias up front, in that I practice in a new practice that is built from the ground up to be a patient-centered medical home. I just -- on the feasibility question, I think becoming a patient-centered medical home is really hard. It's critical. Arguably, it's not feasible. Time will tell.

But the measure itself I'm not sure is not feasible. I think what's hard is actually doing the work. Submitting the stuff is only hard if you haven't done the work, and you actually have to do the work.

So I just want to make the distinction. I think it is really hard, but I think the measure is reasonable to reflect all the work that has to go into actually doing this as a practice.

CO-CHAIR CASEY: Lorna.

MEMBER LYNN: So I know that this

concept has evolved over the past probably almost decade with NCQA and partners, and it might be interesting to hear a little bit about the evolution, particularly most recently to this 2011 version.

I also think that while I understand the idea of breaking us into components to look at things, I also believe that the concept was evolved as a whole. So breaking it into components may not be something that is meaningful, because of the way the whole development came.

I think Jeff has it exactly right. It's not the measurement that is so hard. It's the transformation to being at a place where you can do the measurement that is the hard part.

CO-CHAIR CASEY: Emilio.

MEMBER CARRILLO: Yes. Let me -- the actual application of the backup is very hard. Clearly, I mean, having EHR and having care coordination takes years, and you've got

to have it and that takes work. But the actual act of applying, it's very hard, and it takes time, it takes resources, and we have community physicians who have EHR who are very -- have all the components, but putting it on paper and getting it uploaded is extremely hard.

CO-CHAIR CASEY: Well, I will take the prerogative of the chair and a committee member to add in my comment. But Gerri, do you want to say something.

CO-CHAIR LAMB: I'll go after you.

CO-CHAIR CASEY: No, you go first.

CO-CHAIR LAMB: This is more a question and it will go back, I think, to Karen's questions.

Emilio, you were saying that in the backup documentation, there is a specification of each of these elements within each composite, and I guess the question is, number one, for the other performance measures, which are single performance measures, we have gone

through those specifications.

Clarification here is if -- number one, do we review this component by component. But the other thing is, if we haven't reviewed all those specifications, is this a `trust me'?

MEMBER CARRILLO: Well, I think that this is a little bit like the CAHPS, the CMS CAHPS survey, which has been endorsed by NQF, and this kind of thing -- like the whole is greater than the addition of the parts. And the fact that you have an aggregate measure that has been adopted by CMS and countless states and many others.

So that can one then come out with this is patient-centered medical home, Part 2, that really has -- you know, that takes away maybe ten out of the 100 and claims to be more precise in those matters. So I think that for practical purposes, we need to look at the aggregate in this case, as NQF has done for CAHPS.

CO-CHAIR CASEY: So let me, Karen, before you jump in, add in, first of all, relative to the discussion on CAHPS, having chaired the technical expert panel way back when that actually approved it and heard from the experts, CAHPS survey questions are independently psychometrically validated, and have their own internal reliability, and then are put together as a composite.

So I don't think the analogy is a fair one between CAHPS, and on top of that, individual measures are now used for value-based purchasing.

The correlation between, for example, would recommend or willingness to recommend, versus things like noise and other components aren't a drop-kick.

So I think this is a complex but well thought-out process. I know the late Chuck Darby, who led this at AHRQ, would he be here, would hopefully back me up on that. But I want to be sure that we don't get too far

along in thinking this is the same issue as CAHPS.

The second part of this relates to my own experience, having evaluated the evidence for the state of New Jersey about two to three years ago, on the impact of the patient-centered medical home.

While there's some empiric evidence, in that, theoretically, in practice it makes sense to have a unifying approach to defining the components of a care delivery locus. I'll be neutral on this, because I'm not sure through our last care coordination conversation we agreed it was just the physician office.

I don't think that's the intent of NCQA, to assume that all these things add up to some connection with improved outcomes and lower cost.

While I think there may be stories about it, I think the study that just came out yesterday in the American Journal of Managed

Care actually pointed out the evidence still remains quite thin in aggregate. I guess this was a systematic review. Tom, maybe you or Alonzo, if you can get a copy of that and at some point in time, it might be useful to look at.

But I guess the way we look at it, my third point is operationally having had experience with the survey, one is it costs money. The second is it's hard to do, as Jeff pointed out. The third is it actually has been linked to payment, in the sense that payers in our market have applied a per member/per month sort of extra payment.

And the last point is their evaluation has not shown significant change in health outcome. So I'm just trying to hybridize all of these discussions. They don't fit this conversation like some of our other measures. And so I think this is a complex issue.

I can see how we could call it a

composite measure, personally, but I think the point has been well-made by Jerry and others that composites are really composites of other measures that roll up and add into the subtext of the composite measures.

I'm not sure that these have been broken down and analyzed separately. I'm not sure what outcomes they would be, and lastly, and then I'll shut up, this is really in my mind a structural measure, maybe a process measure, but lots of structure in it. So I'll leave it at that. James.

DR. PACE: Yes, I just want to make a comment. Having been close to the group health model and observed the kind of work, and as Jeff pointed out, it's really hard work and it takes time.

But I think these measures really represent best practice than necessary elements, and ultimately what comes out of it has a lot of do with how it's executed and the external forces, what about patients

themselves. But these are the core things that are relevant, and I support that measure for those measures for those reasons.

CO-CHAIR CASEY: Kathleen, and then Karen, I'll let you sort of --

MEMBER ALLER: Yes. I guess I'm a little caught off-guard, because this is a lot of very complex material. Are we going to be expected to vote on this today?

CO-CHAIR CASEY: Yes.

MEMBER ALLER: Because I'm not comfortable voting on something this complex that I haven't reviewed at all, so I may abstain.

CO-CHAIR CASEY: Well, it's a good point. We don't have to vote today, but let's have some more discussion before we decide that. Karen, do you want to chime in?

MEMBER LEE: Yes. I just wanted to make a couple of comments about the CAHPS parallel, because I think these are very different than CAHPS, and also I know that

you've probably heard this distinction before, and part of this is the way we've referred to things in the past.

But NQF does not endorse the CAHPS survey. NQF endorses the measures that come out of the data from the CAHPS survey. And in that regard, there are several which they term composite measures as well, rather than one overall score. But as Don was saying, those individual composite measures that come out of the CAHPS survey are psychometrically analyzed and put together, so that there is internal consistency and they are representing a particular construct.

Now composite measures, you know, we tend to think of them in terms of, you know, having items that correlate together and are really -- can be demonstrated to measure the same construct.

But in the work that the composite measure evaluation framework group did, they recognized that there are also measures that

are put together and people refer to as a clinimetric model, where they're really just conceptually based and they come up with, you know, putting things together that are indicated by the clinical evidence.

So this doesn't exactly fit in that model either, because we're talking about care coordination. But I guess -- and I'm sorry, I missed the beginning part. I know Karen Johnson asked, and we had a problem with our measure submission form, about whether NCQA had done any of this analysis at these composite levels, in terms of how they did their work to identify that these things should go together, and add up to a score that makes sense.

So I don't know if they've had a chance to respond to that yet.

CO-CHAIR CASEY: Well, we haven't asked them to respond yet. But Karen gave an elegant review of the NCQA, I'm sorry the NQF approach to the defining and evaluating

composite measures. So we have that on the front end of this. So I'm going to ask Eva and Jean and then Jeff to respond.

MEMBER POWELL: Thanks. It would help me to understand more what the -- you referred to backup evidence is, because these things seem to me, none of them, things that are actually documented in a chart anywhere. So what exactly is the backup evidence? And then the other question I'll ask is more of a long-range question, so it may be better to be left to later in the discussion, but I'll put it out there.

The discussion about CAHPS, I think, is really important, because what strikes me is if this is only essentially clinician documentation or attestation, which it seems like it is, it really has some meaning, but not really a lot of meaning.

The rest of the meaning comes from things like the CAHPS survey, and I'm wondering if this measure could be of a lot

more value, given that these individual measures track fairly well with some of the things that CAHPS tries to get at, if there might be some future measure that we task the measure developer with to have a composite of CAHPS scores and clinician input. Because, to me, that really would be where the value is, because it kind of gets at James point, is that this is dependent on a lot of things. So, anyway, those are my two points.

DR. BURSTIN: And I'll just mention, and NCQA may want to speak to this as well, but there is a medical home CAHPS that is being finalized, tested, which we're expecting to get later in the year. It's just that this is before that.

I think we'd love to see ultimately analyses that show whether the system assessment by the practice in fact correlates with that. That tool is not done yet though.

CO-CHAIR CASEY: So I'm going to hold on letting NCQA respond, so we get

everything out, because I think it will be more efficient, and I'm going to ask Jean then to comment or ask --

MEMBER MALOUIN: Yes, thanks. So I just had a question. I'm just confused about how this relates to the NCQA certification process for patient-centered medical homes. Is this a parallel process? Is this the certification process? Is this something totally different? So that's just a question I have.

CO-CHAIR CASEY: Yes, and again, my understanding and my experience is that you have to go through this survey as a part of certification. So NCQA can clarify that. But Jeff, let's get your comments, and then I think NCQA's heard kind of what the themes are and they can respond en bloc.

MEMBER GREENBERG: Yes. This one strikes me as it's different from a lot of the other measures we've looked at. I mean, I'm not even sure it's really a performance

measure versus a certification or recognition award. I mean, the other measures say med rec.

You're really saying if you did it, you've done something good, and if you didn't do med rec, you've failed at something. I'm not sure I'd go so far as to say if you don't do this, then you're not an effective medical home. I think there's -- you know, it's not a one-size-fits-all thing.

I think it's good. This is a recognition of good behavior and good structure, but it's not necessarily like if you do it slightly differently and don't meet this, then you've failed. So I guess it's just interesting. I guess that's okay. It seems like more like more of a recognition award than it is a true performance measure.

CO-CHAIR CASEY: Would it be the case, though, Jeff --

MEMBER GREENBERG: And I'm not sure that -- I wouldn't vote it down for that.

It's just worth noting, I thought.

CO-CHAIR CASEY: Given that what we've identified are some terms in the past that have created some concern about uncertainty about what it means, that having a process like this would actually give more discrete meaning to what is intended by having a medical home?

MEMBER GREENBERG: Perhaps. I'm just not sure I'm ready to say that these and only these six things are what it is to be a medical home, and anyone who does it slightly differently is failing. That's what I mean. That's what I'm not comfortable with, so -

CO-CHAIR CASEY: Okay. Gerri?

CO-CHAIR LAMB: My comment follows on Jeff's. When I look at the composite elements and I think about the preferred practices, I get excited about that, because these, I think as several of you have said, get closer conceptually to key elements of care coordination, and potentially as

individual items could help us move for performance measurement.

The issue here is exactly the questions for me that you all are raising, which is can we look at them as performance measures, so that we can begin to take a look at, like, Element 3C, which is care management? What does that mean? What's the process? Where are we pushing it?

So at a gestalt level, this is really, I think, very foundational to moving things forward. Where I get into more ambivalence is translating this into performance measurement.

CO-CHAIR CASEY: We have the luxury of having Dr. Rich Antonelli from Boston Children's here, and Rich, for those of you that don't know him, is a pediatrician extraordinnaire who's been working on this issue in care coordination in his environment.

Rich also is an active member of the Measures Application Partnership, and I think,

Rich, you're on the group looking at care coordination.

So we sort of when we started off on this journey of our work communicated with Rich and felt that it would be useful for him to be in the room to hear this discussion, so that we could translate -- he could be the translator back to MAP about the richness of this discussion.

So, Rich, I'm going to ask Anne-Marie and Karen to comment, and then if you wouldn't mind providing some input to this discussion, I think it would be helpful to help us sort through some of the issues. Is that fair? So, Anne-Marie?

MEMBER AUDET: Mine is getting a little bit more back into the weeds, and I'm anchoring my thinking about the actual -- the NQF process of measure endorsement. And I think if you look at all of the 23 or 26 elements that make every domain, there are some elements, if we are to vote on them

separately, that could make really good measures, that we haven't even -- that I don't think have been endorsed as measures.

So I'm thinking about the one Gerri mentioned, care management. There's -- whatever. There's a number there that could be individual performance measures, but we haven't gone through the process of endorsing those measures.

And then there are things in there that, as everyone has said, because it is a certification process, that are really not measures. So the practice demonstrates improved performance. That's not something that, you know, would be a measure that we would vote on, yet it's part of what defines a medical home.

So there are differences in some of these elements, and going back to the beginning of this conversation about the criteria for us to go through a composite measure, I don't think we meet them, if we're

sticking to that.

But otherwise I think we could start to get a lot of really rich potential measures of care coordination, that we've been wanting all these two days.

CO-CHAIR CASEY: So it's an excellent set of points, Anne-Marie, and I think quite frankly for NCQA, this is relatively new ground for us. You know, I mean, people on the Steering Committee side of measures endorsement.

So we may not get the full resolution, but we want to have a full discussion today on what to do. So don't be nervous if you feel like we're required to finish the job here. It sounds like there's enough uncertainty that we need to have more dialogue.

But we're open to trying to make that decision later on. Karen, do you want to add in, and then Rich, if you could get in position on a microphone for us.

MEMBER FARRIS: So I've been sitting here reading through the specification, and I think each of us must review the specification to fully understand what's going on. Because if you just read the submission, you can't get it.

And maybe everybody's read it and I'm the only person sitting here reading it right this second. But we have got to review that, and when you read it, I'm like, oh yeah, that's pretty cool. That sounds like care transition, yeah, yeah, yeah.

And then my question is, you know, just how did they come up with the ratings. What's 100 percent, what's 75? How are those sort of measurement scales established and were factor analyses done to put these measures together, some more psychometric things. But we have got to look at the specification.

CO-CHAIR CASEY: Yes, as I recall, the survey itself is somewhere in the range of

between 100 and 200 pages, as I recall. So -- 118?

MEMBER FARRIS: This one -- yes. The specification is just 54. So everybody just get it up there and let's just --

CO-CHAIR CASEY: So Rich, can you help us slog through the mud here, please?

DR. GIOVANNETTI: Just before we get into the more conceptual discussion, and I don't mean to -- if that's how you want to do it. But I think that there's a lot of questions that were raised about the measure that I think would be helpful to understand for the discussion going forward.

CO-CHAIR CASEY: Yes, so let's just have Rich finish, and then we'll move into your response.

DR. ANTONELLI: Good morning everybody, and I actually apologize, because I just got off a conference call ten minutes ago. We're building a medical home system for the entire southeast coast of Massachusetts,

and it started an hour ago. So this couldn't be any more relevant.

I'm going to limit my remarks, because this afternoon I actually get to sit at that table with you, to talk about the strategic planning. But they are pertinent, what I have to say here. And what I mean by that is I was actually part of the group that put together the PCMH the first time around, and then the piece that was always the most anxiety-provoking for me was the care coordination piece.

So much was tied to the primary care provider and then eventually it evolved to the primary care setting, and there was never really any significant measurable things, other than some process measures and maybe a structural measure or two, to get across those silos.

And so forgive me, this comment is going to be extremely anchored to care coordination rather than necessarily the

patient- and family-centered medical home. So I'm not exactly sure what a medical home system is, unless all of the components are in play with respect to measuring and accountability.

Subspecialty providers, primary care providers, community providers -- wearing my pediatric or if I was a geriatric hat -- housing, food security, education, et cetera, et cetera. So I sort of struggle with measures that go around the so-called PCMH for care coordination, because of my inability to structure accountability.

I don't know if that's helpful yet, but I've got a whole lot of stuff that I can back that up with. But I've been sort of holding back for the afternoon conversation.

CO-CHAIR CASEY: Yes, and I think what's important, Rich, is for you to listen in on the conversation here and drink that in for the MAP as well. But -- so let's give NCQA their long-awaited place on the floor,

and let's try to -- I mean, I think answering specific details is important, but let's start with the higher level concerns and work our way down that way.

DR. GIOVANNETTI: Thank you. I have many pages of notes, so I'm going to try to -- I feel like I'm back on the debate team, trying to organize all of my different note cards.

So I'm going to start at a kind of higher level of why are you seeing this today, and why are you seeing this in the way that it's being presented to you today. This is a measure that was up for reendorsement, so this was maintenance.

Came around, and we were kind of caught off guard because a lot of forms have changed and everything, so we worked very closely with NQF staff, in terms of figuring out what was the best way to bring this forward. So this is being -- and part of the issue here is that this survey, which is

different than our recognition program.

So this is the survey that's used in our recognition program, but this is not the recognition program. We're providing the survey to the public free of charge. We want it really to be a tool that practices can use for their own quality improvement.

So this is not part of NCQA's patient-centered medical home recognition program. It has a different name. It's medical home system survey. However, this tool was developed in totality. It was not developed as individual measures. All of the measures need to go together.

So the reason you weren't presented with, say, six submissions or 27 or getting down to the factor level, you know, 150, was because it's an all or nothing sort of thing. If you were to vote down any one of them, it would be conflicting with what we have at NCQA.

So we're asking -- now, this is new.

There's been a lot in this committee that I think is new to the NQF process. It's different. I don't think that's a bad thing. It's just trying to branch a new path for NQF and what they are endorsing.

So the reason you're not getting six submissions is that all six have to go to together. You can't vote for five and not vote for one. They all need to go together. All of the elements within each factor need to go to together. All of the items within each element need to go together.

So that's kind of how it has been presented to you the way that it is, and I encourage you to look over the specifications document, because that really includes all of the details about how do we collect this data.

Moving on to the next point about the feasibility, I will say that, yes, this is very difficult for practices. We've done a lot of focus groups and a lot of work with practices to make this as seamless a process

as possible.

However, what I will say is that all of our focus groups have shown that the process of putting together the documentation that's required for this is in and of itself what helps the practice become a medical home.

We've talked to many physicians who have said, oh, I'm a medical-centered home. I do all of those things. But when you get down to it, it's not a documented process. It's not a process that everyone on the team is all on board with, that everybody knows what's going on.

So the actual process of writing it down, having manuals, having standard practices is what helps the practice become a medical home, and we've seen that over and over again.

So I will say that, yes, it's difficult. Yes, it costs money for practices to get the NCQA certification, but it also costs them resources to develop the -- to

develop all the documentation. And that's something that we're very fortunate that a lot of states and different programs have been helping practices with, because practices often do need help to get this through.

However, this tool is not the NCQA certification survey. Well, it is, but we're not putting forward certification. We're putting forward a tool that can be used for quality improvement. It can be used for practices to determine where they stand to national benchmarks, and for practices to determine their readiness to apply for NCQA certification, or maybe a different certification.

This is a tool that is really just telling you, based off of what we have determined is a valid set of instruments or set of measures, both structure and process, that define a medical home, how close are you to that? How much -- how many of those are you meeting?

So that's kind of the intent of this measure. Getting to the psychometric testing and Karen's specific questions, this measure does not test a latent concept. This is not something like satisfaction with care. So for that reason, a lot of psychometric tests don't really apply here, and I can get down to some of the nitty-gritty.

So for example, how did each item contribute to the variability? Well, we did that analysis, but it didn't really make a lot of sense, because these -- each individual factor. So for example, do you have after-hour office telephone access does not necessarily relate to do you have an electronic system that patients can access.

However, those are in the same element or the same composite, because they all deal with access. So that's kind of why, when we ran this test, the internal consistency test, we didn't see a lot, but we didn't really expect to see it, because we're

not getting at a latent construct. These are not multiple measures of the same construct. These are multiple measures of different pieces of the puzzle.

So just because you're missing one or two doesn't necessarily relate to whether or not you --

CO-CHAIR CASEY: Can I just clarify? I think we weren't intending to suggest that we apply psychometric-type validation to this. I think we were just trying to point out it's hard to do apples to apples with H-CAHPS. That was the only --

DR. GIOVANNETTI: Yes, these are mostly in discussing the questions that Karen raised, about how each item contributes to the variability. Those sorts of testing was not done. Well, it was done, but it wasn't really meaningful.

Okay. So I think some of those are the big level items. I'll talk a little bit about the evidence for this, and what we have

been starting to see. A lot of this is really just starting to come out, because it takes a while for the evidence to show up, and it takes a while for practices to become really full-functioning medical homes.

We have two that are in your submission, but I found an additional one. Three peer-reviewed articles on the NCQA-specific recognized medical home that have shown improved patient outcomes specifically for diabetes care, improved patient satisfaction and improved physician and staff satisfaction.

So we are starting to see this. We additionally have a study which unfortunately was not ready for the publication at the time of this submission, but has shown reduced hospitalizations and reduced ER visits in North Carolina patient-centered medical homes.

So we are starting to see some real, hard outcomes that are coming out of this. Now it's true in the past some of the other

medical home models have not shown the same hard outcomes. But ours, the specific model that we're presenting to you here today, we are starting to see those hard patient outcomes and cost savings resulting from implementation of this practice.

Let me see. In terms of the weighting and the justification for the weighting, this was done through a Delphi process with our panel. So -- and that is one of the attachments that was put into the survey.

We had a panel of experts, including Ed Wagner and Mary Naylor and other people, and they used a Delphi process to determine the weighting of importance for all of these different elements.

Oh, and then finally, you know, something that's not included in here, but we do have a CAHPS PCMH survey that is out and publicly available, and part of our certification process includes special

recognition for additionally using that. But we're trying to keep, not make this too onerous for all of you, so that's why that's not in here today.

But that is something that you will likely be seeing again in the future. Okay. I think I'm going to stop there, and then let others speak.

CO-CHAIR CASEY: So one other question to address is this notion that NQF measures, we have sort of this split between quality improvement and accountability, and there's a tendency to believe that QI-only measures are somewhat weaker in terms of the goals of NQF's ability to create measures for accountability. Can you address that question for us?

DR. GIOVANNETTI: So going off of the -- so I will say that what we are certifying that what we put in the application was both quality improvement and public reporting, because this is something that is

publicly reported through NCQA.

We report the number of patient-centered medical homes, both practices and clinicians in each state. So in terms of accountability, you know, for this measure, the practice is the accountable unit, and that the practice is the one, the level at which we are measuring all of this.

So I think I just need some more clarification about what information you're looking for.

CO-CHAIR CASEY: Well I guess when you say "public reporting," then, is that those that have certified through NCQA that you publicly report, or all practices that have used the survey?

DR. GIOVANNETTI: So we only do the ones that are certified. That's what we report. I will say that the process, those who choose to go through the certification, very low rate of people who do not pass the certification.

So I don't think it's a true representation of -- we don't have the capability to say out of every single practice out there, what percentage are patient-centered medical homes.

CO-CHAIR CASEY: Other comments from NCQA?

MR. REHM: Here we go. Sorry. Following up on the comments about what was going on in New York state, in some ways the accountability is inverted, because in this case, many payers, health plans and employers are providing incremental additional payments to support the patient-centered medical home.

So it's not pay for performance. It's almost prospective. If you build it, we'll be there for you.

CO-CHAIR CASEY: Karen Pace, do you want to --

DR. PACE: Yes. I just had a question, because you talk about public reporting, who's certified. What we're asking

about public reporting of the measures that you've put forward for endorsement. So are you reporting the scores for these composite measures that you're putting forward for consideration for endorsement?

DR. BARTON: I think NCQA has it hands full with its certification program, and we would not at this time report on the variety of ways, were this to be endorsed, the variety of ways that we can imagine, and probably some we can't imagine, in which it might be used.

DR. PACE: No. I understand --

DR. BARTON: We're not set up to do that, but I don't think that we would close the door and say we never would. But if a state or a county or a region sought to use a tool like this and wanted to publicly report it, you know, I think that they -- we would be first in line to encourage them to do so, and maybe we could develop a capacity for it.

DR. PACE: But it's not being

publicly reported now is what you're saying?

CO-CHAIR CASEY: Well, well, let me just -- because we're in the middle of this. They actually then have a subcomposite, which is your Level 1, your Level 2 and your Level 3, and I believe you do report that.

So it would be how many points -- if you get so many points, then you're Level 1. If you get more points, you're Level 2, and more points, then Level 3. Right, right, right. So they do have some ion sort of stratifying this, but it's just adding up the points. So any other comments from the NCQA team?

(No response.)

CO-CHAIR CASEY: Does AMA want to say anything? No, no, okay. Let's have Denise, who I know has had her card up for a while.

MS. DORIAN: Well, I'm completely lost, because it seems like I'm out of the loop, and there's a proliferation of, you

know, surveys and tools for the new structures. I've been a government official, you know, who loves to have a survey that I can implement at the state level.

So my question is I heard there's a medical home CAHPS, and then this medical home survey, and I'm trying to reconcile in my mind all these tools, and I'm thinking of all the state officials out there that will pluck one or the other or both, and I guess I'm really worried about burden.

I mean I'm really worried about Jeff and these guys out here in practice, and James, because data collection is not cheap, free, and so how do all these surveys fit together for the poor medical homes?

CO-CHAIR CASEY: Karen.

MEMBER FARRIS: So I just want to go back to one psychometric question. So if you're reporting a composite measure, are you telling us that all the elements in that are not related, because if that's what you're

telling us, then how do you interpret the composite measure?

I'm not following. I'm not asking about each specific item and its relation to the element, okay. I'm talking about then your six elements that would relate to the bigger concept. Okay.

CO-CHAIR CASEY: Go ahead.

DR. GIOVANNETTI: Okay. Well, I'll go in sequential order. So first I'll answer about the PCMH CAHPS, medical home CAHPS, is a patient-reported survey that asks about patient experiences in a medical home. It is an optional part of the NCQA certification to become a patient-centered medical home. It is not part of what you are looking at here today.

What you are looking at here today is called a survey, because it is a survey in which a practice reports and provides backup documentation for the structures and processes which make up a medical home. So in that

respect, yes, they're different. They're getting a different concept.

The patient-centered medical home CAHPS is something that was designed to add to what the general CAHPS is, to really see what is the patient's experience of the medical home. Because as you can see, this is all structure and process, and I don't want to go back to the, you know.

Yes, it is difficult for a practice to get certified. The recent revisions from 2008 version to the 2011 version have tried to make a lot of this simpler. NCQA is always working with the practices, to try to simplify this process as much as possible, while keeping the integrity of the program alive.

So you know, like I said, the actual process of putting together the documentation is part of the transformation into a patient-centered medical home.

As to the issue around the composites, so these items are conceptually

linked together. They conceptually link to the chronic care model and the joint principles that were put forward by the multiple medical associations.

This was submitted as a composite measure, based off of discussions with NQF, because that's the way that the measure is organized. But it's not a composite measure, in that it's looking at a latent construct of access.

There may be that a practice has several elements within the access domain, but it's not necessarily saying that because they have one access to one element, that they are also likely to have the rest of the elements. It's just -- it doesn't work the same way as a survey which is really trying to use multiple questions to get at a latent construct.

CO-CHAIR CASEY: So I want to call time on this, because we are not going to finish this today. So I think there's enough

questions, uncertainty, uncomfortableness and willingness to think harder about a lot of the issues and questions.

So I've been having a discussion with Gerri and Helen and Karen about considering if we perhaps move this into a work group, not today, and that we help -- we ask for help and guidance from NCQA around clarifying some of the technical issues that still may be looming, and that we not vote on this today, because I don't think anyone on this committee is ready to vote, based upon what we're hearing.

I think -- is everyone sort of comfortable with that judgment at this point? I don't want to disappoint NCQA, but I really think that Gerri and I feel, and I think Helen backs us up, we need more work on this, because there's a lot of moving parts that we're not used to dealing with.

So the good news is we're actually trying to get to yes on this. I think that's

where everyone's head is at and heart. So because intuitively, we obviously are looking at all these other measures and saying this is really getting at the heart of it. James confirmed it, and Rich spoke about it as well.

So are you, and I don't have -- I don't think we've defined exactly what we're going to do next, but I think there's probably going to be a structured dialogue, and maybe Karen you can, if you're available, help us.

And you know, I don't know how we're going to sort out volunteers, but I think we're going to have to probably put this one on hold, at least for the vote for today. So Nicole, you're off the hook. Is anyone uncomfortable with that approach, knowing that we haven't really gotten specific about what's next?

(No response.)

MEMBER LEWIS: This is Julie. I'm very comfortable on my end with that.

CO-CHAIR CASEY: Because you're

uncomfortable?

MEMBER LEWIS: Because I'm uncomfortable, I'm comfortable, yes.

CO-CHAIR CASEY: Right, okay. Good, good, good, good. Okay. So that's the good news. We still have a lot of work to do. It is -- well, I think we could certainly ask those. I suspect they're going to be a lot. How many would like to be part of this work group? Raise your hand.

(Show of hands.)

CO-CHAIR CASEY: So we can capture -- can you capture that? I think that's a lot of people.

Yes. Who doesn't want to be part of it? I don't think you're going to get anyone putting their hand up.

So we'll send a sign-up sheet around, and by no means does that mean that this group is making a decision without the consensus of the whole group.

But I think we're going to have to

think through being a little more organized about this one, because there are a lot of -- there's a lot of opportunity here, and again, we want to be sure we come out the other end with the best value to the membership and the end users of this as a process. So yes Jean?

MEMBER MALOUIN: So I just wanted to say I don't know how familiar everyone is around the table with the PCMH designation or certification process. But there are a number of different organizations that have their own processes for recognizing medical homes.

For instance, in Michigan, we use the, primarily the Blue Cross/Blue Shield designation program, which we have the largest number of medical homes, I think, in the country in Michigan, and Minnesota has their own designation program. URAC has their own.

So I guess what I would like to see happen for this work group that works on this is that if NQF is going to endorse one medical home model, that it really is representative

of the major features of all of these other medical home recognition programs as well, because I think it would --

CO-CHAIR CASEY: Well, I think it's a great point, but in fairness to NQF, they did put out a proposal for submitting measures, and this is what they got. So everyone in the rest of the world had an opportunity to respond to that request. So we have to take what we can.

But that being said, your point is to be sensitive to the fact that this is not the only process. So I'm just trying to be fair to the process that we've asked the country to go through, in terms of submitting measures.

MEMBER MALOUIN: Right. I guess I'm just thinking that, to make sure, I guess what I was trying to say was that we want to really review these carefully, and make sure that we feel they're representative of what a patient-centered medical home should be.

CO-CHAIR CASEY: Okay. Comment from NCQA, and then we're going to move on.

MR. REHM: And thanks for that, and you know, from a level playing field perspective, the call for measures was there. This was -- we were invited to do this. Our program, our certification program is, to put it mildly, one of our most successful efforts in NCQA's 21 years.

So this was something we weren't sure of how to do it, and we worked with NQF to do it right. This is just a study, and the Minnesota primary care homes that were used in this study were all NCQA. So some states have essentially, are using this model as well. I can't speak to the Michigan one, but I wouldn't be surprised if they were quite similar. But in the Minnesota case, those are the NCQA programs.

CO-CHAIR CASEY: So I'm getting tired and hungry, and I'm wondering if even though I know we're going to bring a close to

this discussion right now, we have the task of reviewing the competing measures, which is the next agenda item, which will take us out of the vote into trying to evaluate measures that are related, and get the sense of the committee in terms of whether there should be harmonization, or whether there's enough distinction between the measures to keep them separate. So, and getting that type of feedback.

But would it be fair to say that everyone would like to break for lunch at this point, and come back in about -- what time, Karen, would you like us back?

Well, we're going to have a working lunch, so come back at about 12:22 and we'll -- you can eat -- there's going to be some discussion, I think, by the staff about what's at task here.

Then that will give us the opportunity, then, to spend the rest of the time looking at the preferred practices in our

small groups and coming back to the work that we're going to do to hone in on the preferred practices. So does that make sense? All right, go to it.

(Whereupon, the above-entitled matter went off the record at 12:08 p.m. and resumed at 12:23 p.m)

A F T E R N O O N S E S S I O N

12:23 p.m.

CO-CHAIR LAMB: What we're going to go into next is related and competing measures, and I guess the first comment is just relax. We are not going to vote on it today, okay? This is a chance to listen to the process, understand the process and what the deliverable is, so that everybody --

The goal is to understand how we're going to be reviewing these and then what we're going to be voting on, and the implications for the measures. So really this is a chance to get oriented to the related and competing measures comparison process. We're going to go through an example together.

But then what we're going to do is convene our work groups, to make recommendations, and we'll do this online. Okay. So we will not be voting on this today. It's a chance to ask your questions. Everybody be clear on the steps in doing this

review, as well as the implications. Does that make sense? Okay. Is that good for everybody? Okay, good.

And so when Helen gets back, is Karen doing any start on this, or is this primarily Helen and Lauralei?

Karen's going to do it. Okay, and so this is a kind of sit back, listen, enjoy your lunch, and if you have questions in terms of what am I supposed to be doing and what's next steps, that would be very appropriate to ask, okay.

CO-CHAIR CASEY: Gerri, just to -- and you have the supporting document. You should all have a copy of that. Does everyone have that either electronically or --

CO-CHAIR LAMB: Okay. Related and Competing Measures, Comparison Tables. Did everyone get that? Oh, you will get that, right.

Right. So this document, we're not going to go through yet. We're going to kind

of just go through the framework first. Then Karen will pass this out, and then we'll look at one set of measures specifically. Is that okay? All right.

Related and Competing Measures Discussion

DR. PACE: So as you know, NQF has endorsed many measures over the last few years especially, and so more and more, we're getting measures that are related or competing, and presents issues of, you know, do we want -- you know, generally we would prefer to endorse one measure on a topic than having five, because then how do you have a standard?

If we have measures that have related concepts, we would like them to be defined consistently as much as possible. So that's led to some work on what we call measure harmonization and then competing measures. So as you'll see up on the slides, and most of this information that I'm going through has been in -- is in the document that

you've looked at, where it has the NQF measure evaluation criteria and guidance.

But I'm just going to -- we purposefully didn't get into this with you, because you first had to evaluate the individual measures, rather than starting to compare things, until we knew that you really are recommending something potentially go forward.

So your votes on overall suitability, if you notice, there's a note that the final recommendation is actually pending resolution of any related and competing measures issue.

So first let me start with just explaining what we mean by a related and competing measures. So basically, when we're talking about these measures, most of them have a numerator or measure focus, and a denominator, what target population does this particular process or structure or outcome apply to.

So when we're talking about competing measures, we're talking about measures where they're trying to measure the same thing in the same target population. Now we know that, you know, the measure specifications are going to be different. But that doesn't make it not competing, you know.

If they're trying to measure mortality of COPD patients, it doesn't matter that one measure is specified for health plan and another for hospitals.

We will consider them competing, and that's part of what we ask committees to look through, is do we need both of those measures, or is there some way that a measure can have a broader applicability.

So we just start with looking at, you know, kind of those overall concepts. What's it trying to measure and in what population, you know. So hospitalized patients, for example.

Related measures, on the other hand,

could have the similar in either the measure focus or the target population. So for example, we may have a measure of, and this has been one of our challenges, influenza immunization as the measure focus, and then we had measures of target populations of COPD patients, MI patients, nursing home patients, hospital patients, physician office patients, you know, 12 measures about influenza immunization.

So first of all, do we need all those. That's another question. But secondly, if we do have multiple measures, do we define what, how you meet the measure criteria of the numerator, that the patient received the influenza immunization the same way.

Or, on the other hand, if we have two measures that are focused on the target population of patients with diabetes, have we defined diabetes the same way across those measures?

So the idea is that we have some consistency, that you know, if we have to have multiple measures because they're in different settings and different data sources. Do they make sense? Are they, you know, really consistent, as much as possible?

Okay, next slide. So we've developed some algorithms, in terms of addressing these. So you know, the first thing is does the measure meet all four criteria, which you've already done. So if a measure hasn't, you know, if you haven't said that it's overall suitable for NQF endorsement, then we don't deal with it anymore.

So then we look at are there potentially related or competing measures, and that's what the care coordination team has been doing, is identifying those, and that's what you have in those tables, is just the measure specifications, where they think that there are related or competing measures.

Then we need to look at the specifications, and really determine are they related or competing. If not, then the recommendation goes forward. If they have the same concepts for the measure focus but different patient populations or target populations, the first question is could we have one measure that applies broadly?

So you know, the immunization example I gave you, the recommendation, you know, the evidence indicates that now everyone should have an influenza immunization. So why do we need measures parsed out by patient condition or settings, for example.

So that's a question. Do we really -- can we have one measure that has broad applicability, rather than you know, five parsed out measures? So if yes, then you can get a combined measure or one that's broader applicable, that's the one that should be recommended.

So if that can't happen, then we go

on to the next slide. If they address the same concepts for the measure focus, let's see. I'm having trouble reading here. Oh okay, right.

So now we're talking about best measures. So if they do address both the same concepts, the measure focus and the target population, then we want you to compare them with the goal of selecting the best measure.

NQF really prefers to have one measure for a specific topic and target population, because we're talking about standards. So when you start having two measures trying to do the same thing but differently, it creates confusion in terms of interpretation, potentially measurement burden for providers that have to provide data, etcetera.

Okay. So we'll compare the specifications, and you know, one of the things that could be asked is whether the measure stewards can get together and submit

one measure, and can they resolve who owns that measure or have joint ownership.

If that's not the case, then we really do need to have you compare the measures, and we will have you compare the measures criteria by criteria, to determine if one measure really is superior. So does one measure, is one measure really more reliable and valid, for example, or is one measure much more feasible?

So ideally, you'll be able to compare the measures, not only compare the specifications, but how they really met our criteria, in terms of importance to measure and report, scientific acceptability, usability and feasability.

So if you can identify a superior measure, that one is the one should recommend, and basically the implication of that is that the other measure is not recommended for endorsement.

If you feel you cannot identify

superiority or there may be reasons that we need multiple measures, then you can make the recommendation, but you have to provide a justification to, you know, for your recommendation, for public comment, for review, etcetera.

And we'll just say that this has been an increasing issue, and every time we put forward to our Consensus Standards Approval Committee and board two measures on the same topic, they always ask us why are two measures coming forward? So they want to see that justification, of why is it necessary.

Okay, and then -- and one thing that -- so I'll just give you -- well, we'll get to that in a minute. So in the algorithm about addressing related measures for harmonization, again this is either the measure focus, the numerator or the target population are similar.

We'll ask you to compare the specifications, to see if they are completely

harmonized. If yes, then good to go. If no, are the differences justified, and oh, okay. I think that might be a mistake, so I need to clarify that. Sorry, these are my slides and I think I've got something wrong here.

So with the comparing the specifications, if they're harmonized, then the answer is yes, you would recommend the measures. If no, then we can send that back to the measure developers, for them to get together and say how can you come up with a consistent definition for what is a transition record, or a consistent definition for medication reconciliation.

If the Steering Committee has a very specific recommendation of what you think is a preferred definition, you can provide that. But you can also just say, you know, we really need you to come together and make some decisions here about a consistent definition.

So just to go on to the next slide, I'll make a couple of other comments on these

last slides. So if we're assessing for superiority, again as I mentioned, you're going to look at these measures not only in their specifications, but also how did they match up against our criteria for impact, opportunity and evidence, reliability and validity, usability and feasibility.

Okay, next slide. And as I said, if you feel you have to recommend two competing measures, what's the justification? What's the value?

So for example, sometimes in this move to getting measures specified in e-measure formats for electronic health records, we may want two measures because one is going to be in e-measure format and the other not, at this point in time.

Or maybe, because you have two measures, one is all payer and one is only Medicare, and at this point in time, we can't somehow get one measure to do both. So the idea is to look at what's the value of having

two measures, and then what's the burden? What are the potential problems, and then kind of weigh that and provide your justification.

Then the next one is assessing justification for lack of harmonization. So if you have related measures with two definitions, is there a justification for it? The first thing we ask you to look at is first that the evidence should guide any differences.

So for example, you may have -- so say for example on the immunization measure, if the evidence was different, in terms of say pediatric patients or adult patients, then that would justify having perhaps differences in the measures.

So the first thing is does the evidence indicate that something should be different, based on the different target populations? Then you know, the other thing to kind of keep in mind, again, this is, you know, is it evidence that dictates the

difference, or is it a measure developer's kind of preferences of how they want to develop a measure?

And again, our goal is to have things as harmonized as possible, and to hopefully get the measure developers to get that worked out. And again, looking at the value and burden across, for lack of harmonization.

Okay. So I'm going to stop there, and again, when we do some follow-up work here, we'll make sure you have those algorithms. As I said, they were in that one document with all of the guidance, and now I think we wanted to look at a specific pair.

CO-CHAIR LAMB: We'll go into a specific example, but before we do that, any questions for Karen, just on the process?

MEMBER HEURTIN-ROBERTS: Excuse me. You had, I don't remember the slide. There was value and I forget what the other thing was.

DR. PACE: Burden.

MEMBER HEURTIN-ROBERTS: Value and burden, right. And then you had a number of bullet points. To justify something in terms of value or burden, would all of those conditions need to be met? Or is that just an example.

DR. PACE: No. These are examples.

MEMBER HEURTIN-ROBERTS: Okay.

DR. PACE: And unfortunately, this is one of those areas where it's not black or white, and we need your expertise and judgment to kind of weigh these things. But it's not like a requirement that each one of those has to be met, but things for you to consider.

CO-CHAIR LAMB: Any other questions for Karen before we move into an example? Go ahead, Matt.

MEMBER McNABNEY: You probably, this probably was covered. So if there are similar measures and they're both very, assessed to be good, but one was slightly better than the

other, that one would be endorsed and the other one would not? Could you still be endorsed and not be the preferred?

DR. PACE: No. We would -- if you think one measure is better, that's the one that we would ask you to put forward, and the other one would then no longer be endorsed, or your recommendation would be to endorse the one and not the other, and not endorse the other.

CO-CHAIR LAMB: Any other questions? Okay. We're going to go through an example then.

DR. PACE: Lauralei, which one do you want to -- that you have the evaluation criteria, and then we'll start with looking at this.

MS. DORIAN: The ratings or the --

DR. PACE: We'll start with the specs, but which ones are we going to do?

MS. DORIAN: You have the first two here, 0097 and 0554.

DR. PACE: Okay. So that starts on page seven of this handout, and Karen, I know there's three on here, but aren't there actually six measures in this area? So you all have the bonanza of related measures. So we realize that this is going to take some time, and we're not, I think -

Gerri, did you want to tell them what our plan is, in terms of --

CO-CHAIR LAMB: For this example, I'm thinking maybe if we just do a comparison of two, and not try and do more than that, just so that we get a sense of what the process looks like. Is that okay, so that we don't make it too complicated in the first stage?

What we're going to do after today, after we make sure everybody has a sense of where we're going with this, then Karen and Lauralei will set up a process, so that we'll set up work groups and have everybody do the reviews.

We haven't worked out the full process, but we will likely be doing online voting for this. But there may be a conference call, just to walk through the recommendations, to make sure we're on the same page.

But it will be at a distance, whether it be through online voting, through conference call. But Karen and Lauralei will help us set up that process.

DR. PACE: And I'm wondering, maybe we should look at a competing measures pair. Which ones do you think are competing measures? Do you have eval as far as some of the competing measures rather than related measures?

MS. DORIAN: We've grouped them together so far. We haven't separated them.

DR. PACE: You haven't identified competing versus related? Okay, all right. So then we'll go ahead with that example that's on page seven. So should we -- perhaps

we can look at just the first two, Gerri, just to get us going here.

So we have medication reconciliation, 0097 and then 0554. These are actually from the same developer, so they're probably more harmonized than if they're different developers. But let's look at --

Okay. So you want to do -- which two do you -- okay. Then let's do that, okay. So we'll look at 554 and 646. So the first thing is to kind of look at, you know, across these specifications, you know, where there are differences, and if the differences are really substantive, because obviously different developers may have described things with different words, but it doesn't mean that they're really different.

So maybe let's look at the numerator statements, and first of all, just see are those different. So for 0554, this is medication reconciliation conducted by a prescribing practitioner, clinical pharmacists

or registered nurse, as documented through admin or med record review, on or within 30 days of discharge.

Medication reconciliation is defined as a type of review in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record, on or within 30 days after discharge.

So we can compare that to 646, and this one is patients or caregivers who received a reconciled medication list at the time of discharge, including at a minimum medications in the following categories, to be taken by the patient, prescribed before inpatient stay, that the patient should continue.

I don't want to read this off to you, but there's a list of things here. So I guess some things that occurred to me, and I'm looking at these kind of off the cuff, and I know some of you have gotten into the details

of these measures, so feel free to speak up.

But again, a key question would be how each is defining medication reconciliation. Is that the same across these measures? What medications are counted, and 0554 is, looks like it's was it conducted, versus 0646 is the patient receiving a medication list.

CO-CHAIR LAMB: Karen, so a question.

DR. PACE: Yes.

CO-CHAIR LAMB: If we look at the numerator and just look at the specs, given what you just said are the differences, one is did you do it, and the other is did the patient receive it? Those are getting at different stages of the process. So is -- at that stage, do we say that this is more of a related measure, rather than competing?

We don't get into well, we think whether the patient gets it or not is more important than whether you do it?

DR. PACE: Right, right. So you're right. Technically, we would say that's a related measure versus competing. But one of the things to think through is, you know, and this -- I know this maybe introduces another thing for you to think about, but exactly what you're talking about, it steps along the process.

One of the things that we talk about in our criteria and our Consensus Standards Approval Committee emphasizes, is that we prefer measures that are more proximal to the desired outcome.

So if you think about the steps in the process, you conduct the review; then you give the patient the medication list, and then hopefully the medications, taking the right meds and prevent errors.

So in this case, you know, actually receiving the result of a medication reconciliation process is closer to the desired outcome than the --

MEMBER WAKEFIELD: So, and this may be what you're going to say. It would seem to me that possibly the measure sort of assumed that the patient would get a copy of it, because if you're going to do it, what's the point of doing it if the patient doesn't get a copy of it? So that just might need to be clarified.

DR. PACE: Right. So and that's a good point, because the direction that we've been kind of trying to move developers is to incorporate both concepts. So it's like it's conducted and the patient receives it, rather than having, parsing out these, you know, multiple steps in a process.

To give you another example of what happens in some other, more condition-specific projects, we may have measures about assess a particular lab value, that the practitioner assesses the lab value, orders the lab test, and then there may be a measure about the patients are given the right treatment, based

on the results of that lab test.

And then there may be a measure about the lab test should be within a specific range, kind of a clinical intermediate outcome. You know, the hemoglobin values should be between X and X.

And then we may have a measure about, you know, function or mortality. So do we need a measure for each of those steps? You know, your assess, plan, intervene, outcome, or can we really focus on measures of outcome, intermediate outcome and the intervention that's most directly related to the outcome.

So those are things for you to think about, in terms of, you know, this justification for multiple measures.

CO-CHAIR LAMB: We have a couple of questions. Kathleen?

MEMBER ALLER: Yes. So as I look at these, I mean one is at the end of the inpatient stay. Are we giving the patient a

reconciliation, and then the other is when the patient gets to the outpatient setting, is the provider going through and reconciling?

So those make sense to me that you might want both steps. One has a very detailed definition of what that reconciliation is; the other kind of gives it a general one.

I guess if we said we need both of these measures, I'd love to see that more specific definition incorporated throughout all the measures that use reconciliation.

DR. PACE: Right. So that would actually be a good example of a request for harmonization, right? Okay. Karen?

MEMBER FARRIS: So to follow up with that, it seems to me that 554 and 0097, I think they're competing. I'm not exactly sure, because one's 30 days and one's 60 days, and let's do it once.

Because 0554 is about getting it in the medical record, in the ambulatory setting,

and it allows other practitioners, you know, several practitioners to do it, and that could be opened up probably some more.

And then 0097 is this 60-day window, which we've all sort of said really shouldn't that be a little tighter anyway? So is that an example of competing, whereas 0646 and 0554 are these different steps?

DR. PACE: I think so, I mean because if you think of it just at the kind of broader concept level, they're both trying to do medication reconciliation. Are they both after hospitalization or --

MEMBER FARRIS: 0646 is at discharge.

DR. PACE: Right. But the other two that you're talking about --

MEMBER FARRIS: Are post.

DR. PACE: Yes, right, so and both in hospitalized patients. So that is a good question, and you know the first question is, you know, are they both needed?

You know, where is, you know, the priority, or is there some reason that you would want them at the two stages, or the other option is should it be one measure, you know, that it's happened at 30 and 60 days, in order to really --

I mean if they're both really important, then you know, a question that you can ask is should they be parsed out? So if it's important to do it 30 days and 60 days, if you have two separate measures, then some may be doing well on 30 days, some may be --

I don't know. So I mean those are all questions for you as, you know, the experts in the content, knowing the content and having looked at some of the evidence or what the expectations are.

But I think that's, those could be potentially competing measures, as you've pointed out.

CO-CHAIR LAMB: Karen, that was clear to you? Okay. Anne-Marie?

MEMBER AUDET: There could also be instances where here, just going by the time frame, that the two measures tell you slightly different things. So I'm thinking about 30-day readmissions and 60-day and 90-day readmissions. You know they all tell you slightly different things. So that would be one also criteria.

The other thing about 0554 and 0646, and talk about steps in the process. Since we're involved with care coordination here, I think it's kind of interesting to think that we want to eliminate some of the steps, because in this case, it's the patient receiving.

But there's ultimate value in having the reconcile in somewhere that's accessible. The physician needs it; the nurse practitioner needs it; the home health agency needs it. So there's a lot of people who need it.

So there may be some reasons why we

need to have, be more inclusive when we're thinking about coordination. So there's all these other --

DR. PACE: That's an excellent point, and that's why, you know, we have all of you here at the table, to kind of weigh those pros and cons, the value versus the burden.

CO-CHAIR LAMB: Anne-Marie, you know, that also seems like a wonderful example of how we can link this to the next stage, which is where are the specific priorities and to use what we have as a foundation to say we're missing this piece in the chain, and we really need it, and it may be low-hanging fruit. So that may be really a worthwhile connect. Russ.

MEMBER LEFTWICH: Does the work group suggest specific harmonization or factors that need to be harmonized?

DR. PACE: Sorry. Would you say that again?

MEMBER LEFTWICH: Does the work group suggest specific factors that need to be harmonized?

DR. PACE: You can. I mean you can. If you have really some specific recommendations, such as you want a more defined definition.

MEMBER LEFTWICH: You know, one obvious difference here is 0554 is very prescriptive about who can do the medication reconciliation which, you know, makes it unlike the others on the face.

DR. PACE: Right. So you could -- you can identify those kinds of things where you think that they should harmonize, if possible, or to give you their rationale for why they can't or shouldn't. You can make specific recommendations, or in general you could, you know, send it to them and say, you know, we want you to get together on these and get them as harmonized as possible.

So there's a variety of ways. If

the Steering Committee has some very specific ideas or recommendations, you can provide those to the measure developers.

CO-CHAIR LAMB: Eva.

MEMBER POWELL: I just wanted to, excuse me, add on to what Anne-Marie said, because I think that's absolutely right. On the flip side, I think, given that we're talking about care coordination, there's also probably some circumstances where we need to look kind of at the whole and not the parts, in the sense that, kind of as I was having a discussion at lunch, there's no such thing as care coordination if you're not sharing information.

There's no such thing as care coordination that doesn't cross provider settings. It just simply doesn't exhibit. Inherently, care coordination is all of that. So while it is beneficial to know, you know, what are the individual steps, particularly at this stage of the game where we don't even

really have a consistent definition of care coordination, that it is -- there's value in that.

But then there's also, I think, the tendency to get into so many of the little steps and processes that you miss the entire point, that without the whole, there is no such thing as care coordination.

DR. PACE: Right, and I think that's the things that you'll have to weigh, because you know, if you think about, you know, if you could do, you know, you may on a performance measure do okay on this one and that one but not that one, and ultimately do you end up with care coordination, I think is what your question is?

CO-CHAIR LAMB: Lorna.

MEMBER LYNN: What is NQF's process for retiring measures, which I'm asking because so many organizations rely on NQF-endorsed measures for their internal processes.

DR. PACE: Well, this whole endorsement maintenance process is about, you know, reviewing all measures on a regular schedule, to see if they still meet NQF criteria or meet more rigorous criteria, because NQF has been evolving over time, in more rigorous application of their criteria.

And so the process is just what you're going through. If we, if for example, some of these measures that were previously endorsed you don't recommend for endorsement, that goes out for public comment, in terms of what measures you're recommending and which ones you're not and why.

And we get comment on that, and then you'll respond to those comments, see if that changes your opinion in one way or another. But ultimately, you know, if that gets carried through and there, you know, there's basically agreement and that's how it moves forward, then the measure that is not recommended no longer retains NQF endorsement.

So if you're asking do we take into consideration people who may be using that, that is certainly something that can be factored in. But ultimately, we're asking you to evaluate the measures against the criteria that exist. So at some point if it's not meeting the criteria, or there's a better way of measuring that concept, then that's what we need to put forward.

MS. DORIAN: Karen, just a quick question. One of the things the developers just mentioned to me is that some of these measures have different levels of accountability or different accountable units. So how does that play into the whole process?

DR. PACE: So different levels of analysis. If one's at a hospital level, one's at plan level, one's at a physician level, it's the same things to consider. The first question is do you need separate measures for all those levels, and if not, again, you know, the broadest applicability can apply to

settings, data sources, patient populations or levels of analysis.

One of the things that tends to trip us up in not being able to have one measure with broad applicability is kind of an extension of our siloed health care system. We have measure developers that also work in those silos. They specialize in the data for a particular entity.

So they don't, may not have access to data from another setting, to really apply their measures, specify the measures, test the measures. So those are some very real and practical considerations. Level of analysis.

You know, has it been tested at different levels of analysis, you know, because reliability or even validity may differ when you're getting down to smaller case volume sizes than larger case volume sizes.

So there's a lot of moving parts here, we understand, and a lot of things that

you have to consider. So we're not saying that you have to come down to one measure, but we want you to think through these things. Ultimately, if one measure will do it, that's the preference.

If we need multiple measures, we just need to understand why, and if we need multiple measures then hopefully they're as harmonized as possible so they create as little confusion and burden as possible.

So I guess, you know, that's in a nutshell what we're driving for, and there's no unfortunately formula that we can just, you know, plug in and have it spit out an answer.

CO-CHAIR LAMB: Before I go to Kathleen, Julie, are you still on the line?

MEMBER LEWIS: I'm right here with you.

CO-CHAIR LAMB: Do you have any questions?

MEMBER LEWIS: No. I'm trying to do my best to follow along. I'll admit I'm a

little hazy in points, but I think I'm good for right now.

CO-CHAIR LAMB: Okay, and hopefully we can have access to your slides Kathleen?

MEMBER ALLER: Yes.

DR. PACE: Actually, I'll correct that one slide, and we'll get those to you, as well as again, referring you to the more detailed document that you can follow. The other thing, Lauralei, do you want to put up --

So if we had competing measures, we would also want you to look at how they match up or compare on the criteria. So you know, what we would do is provide to you your ratings on those subcriteria as a starting point.

Now we understand that sometimes committees, as they're learning the process, may have been less consistent in these ratings. So we're not saying that this is the absolute, but it's a starting point. It

identifies like if you really -- if it looked like there were some issues with a particular measure compared to another, to kind of look at that.

So we will provide this information to you as well, especially when you're looking at competing measures, so you can kind of start to hone in on is one measure really superior to another.

CO-CHAIR LAMB: Kathleen, did you have a question?

MEMBER ALLER: Yes, and I think this may be too broad, but I want to ask. As we look at some of these measures and we say well, you know, they're competing things or it would be good to harmonize some of the components, I look at some of them and say but I'd really rather that the measure developers, rather than negotiating this over this manual measure, put their efforts together into creating a harmonized electronic next generation measure, and that betrays my bias

obviously. But is that a valid recommendation?

DR. PACE: Right. Well, I think that's something that we get into your recommendations for future measure development. I mean, you know, we certainly, and that's an NQF priority as well, in terms of moving measures to e-measure specifications that can be taken directly from electronic health records.

You know, issues of measure developers working together, I think you can just make that recommendation. Sometimes that works; sometimes it doesn't. They have different constituencies and things that they're responding to as well.

So I think, you know, it's perfectly within your purview to make those suggestions, that you know, from you know, that in the future, rather than having, for example, maybe right now, because we have one measure that's been tested at the hospital level and another

measure that's been tested at a physician level and they have different data platforms, maybe for now we'd have to live with two measures.

Maybe your recommendation is for the future. Next endorsement cycle, we'd like to see one measure that can accommodate both, you know. So you can make those recommendations, and then see, you know, the measure developers, hopefully over the course of endorsement maintenance, will take a look at that.

But you know, you only have so much that -- and we don't have time, you know. Things that can be harmonized are things that can happen now, and you know, because this project has to move and ultimately come to a conclusion. Our experience is measure harmonization can take a very long time.

CO-CHAIR LAMB: Suzanne.

MEMBER HEURTIN-ROBERTS: Whose responsibility is it to harmonize two

measures?

DR. PACE: Ultimately, it's the measure developers, because they own the measures. So typically what's been happening is that steering committees will ask the measure developers to get together. For example, can they, you know, come up with one definition?

And you know, we also need to think about, you know, if the harmonization is radically going to change the measure, then you invalidated any reliability and validity.

You know, so again, there are limits to what can be done. But the first thing would be to ask them to respond to a question about harmonization, either in general or specific, and to come back to you with either what they've agreed to do, or their rationale for why it's not possible at this point in time, and then you'll have to decide whether you agree with that rationale and understand it and decide what to do at that point.

MEMBER HEURTIN-ROBERTS: And if they say no, we don't want to harmonize this, just because perhaps they have different constituents; they just don't want to do it, does harmonization then not occur?

DR. PACE: Well, harmonization would not occur, because you know, it really -- the developers own those measures. The consequence of that is up to you, whether you would still recommend the measure or not.

CO-CHAIR LAMB: Emilio?

MEMBER CARRILLO: Yes, a simple question. What is the cycle for a measure, in terms of being looked at again formally and voted on or --

DR. PACE: Right. It's every three years at this point. I mean yes, it could be a little more, it could be a little less, because we try -- we want to look at things on a topic basis. But we try to do that on a three-year cycle.

CO-CHAIR LAMB: Okay. Does

everybody feel oriented to what the process is going to look like? You're going to have questions I'm sure. We'll have folks walk with us and walking us through it. But this was intended as an orientation to that next step, of looking at comparisons and overlaps.

So Karen, Lauralei, you'll assist us in kind of getting this process together, so that we can work into that?

DR. PACE: Yes.

CO-CHAIR LAMB: Great. Okay, Karen, did you have a question before we move on?

MEMBER FARRIS: So we're going to get lists of which are related, which are competing and go through these flow charts, and okay.

CO-CHAIR LAMB: I guess what we're envisioning is you've got the document that's starting that, and then we'll have the decision trees that Karen just went through.

And so that we'll set up a process that the work groups can kind of walk through,

which ones are you going to be doing, recommendations, and then maybe having a conference call to talk about that, and then likely online voting. We just don't know the full process at this point.

DR. PACE: One of the things we'll do is kind of get with Gerri and Don, in terms of, you know, in terms of efficient use of time, whether we should start asking the developers.

You know, rather than having work group calls first and then do the developers and back. So we'll work that out with Gerri and Don, in terms of the most efficient way to kind of keep this moving.

CO-CHAIR LAMB: Lorna.

MEMBER LYNN: That's sort of my question was is there an opportunity to ask the developers questions, and probably it would be most efficient to do that through Lauralei and Karen.

CO-CHAIR LAMB: Yes. Actually, you

know, what Lauralei and Karen were suggesting is to build the developers into those discussions, to that we have ready access to their input, which I think Lauralei and Karen will help us do. Dana.

MEMBER ALEXANDER: Yes. I may have missed this, but what is our time line to get this piece of work completed?

CO-CHAIR LAMB: You didn't miss it, because we didn't say it. Karen, Lauralei?

MS. DORIAN: I guess I was thinking that I would send a survey monkey out, to see when we can get everybody together. So then by the time that we have everybody together with the developers and everything, I guess, what do you think Karen? Because I know, didn't the Safety Group just do this as well?

DR. PACE: Well, I guess the first answer is as soon as possible, because this project time line isn't changing, because now we have to deal with this.

So but we obviously need to get you

together, and we may just need to do some things simultaneously, be polling you for some dates and, you know, notify the measure developers that you're going to be asking them questions about these measures.

So but we'll obviously need to get it set up as quickly as possible.

CO-CHAIR LAMB: Did you have another question Emilio? Okay, and is it Marianne.

MEMBER AUDET: This is a question about the three years, so after three years, because a lot of our discussion today and yesterday was extremely rich with recommendations. Some of us were voting on some measures, saying that this is a baby step.

So we expect that three years from now, if these measures come and they're still at this infancy stage, we should not vote on them. I mean I'm not saying that. I'm too brutal here. But you know, I'm trying to kind of raise the bar for what we expect to see in

three years if possible, so at least some movement.

I'm just wondering how you would incorporate that in our process, of looking at measures three years from now, if we volunteer to do this again?

DR. PACE: Well, I think maybe that's something you can work into the work you're going to do this afternoon, because that's going to be focused on future measures. I think we were talking about the more specific; you know, rather than saying, you know, we need measures on transition, specifically what do we need on transition?

And if there are things about, you know, medication reconciliation that would take it to the next step, what is that? You know, what are the things that you want to, specific things that you want the developers to be thinking about, and that can go in your report.

Ultimately, you know, the measure

developers own these measures, and they decide what they're going to put forward. But you know, I think that's, you know, something that, as you're saying, that you're going to be looking for at the next round, and see what was done or what was possible.

Preferred Practices Discussion

CO-CHAIR LAMB: Thanks, Karen. That was a really good lead-in, Anne-Marie, to the next step.

Okay. What we're going to be doing now is what we've been talking about doing this afternoon for a day and a half now, which is moving from the measure review to bridging that world that we've been talking about, from the baby steps into what now, and where the value is.

And so a little bit about the process, and then Don and I are going to just do a few introductory comments. The process being is getting into the work groups for the preferred practices, discussing where you

think the priorities should be, and as Karen has said, the more specific, the better.

Part of the work right now is that not only will our recommendations go forward on measures, as well as what we've just been talking about with the comparisons, but a document will go also out for public comment, related to our recommendations for how to move this forward.

Where's the value? What kinds of measures need to be out there, to really capture, and I think Eva put it really well, where's the value in care coordination, and what do we want to put forward, in terms of priorities for the future, and again, the more specific, the better.

So one of the deliverables that we didn't talk about when we first got together in this group, but that NQF has supported, is a document stating what we believe in terms of priorities going forward, which Don and I have felt has been really critically important,

particularly in the face of not getting any new care coordination measures, okay.

So this is a real opportunity to put forward where are the priorities, to have that discussion. What we're anticipating, and NQF frequently uses this process, is that today, to generate priorities as specific as possible, and then to have some discussion today.

But then we will actually do a prioritization and talk about that, in terms of what that document will look like going forward, and it will go out for public review.

Is that clear? Does that make sense in terms of what we're going to be doing today is generating that priority list as specific as possible. In the survey, you'll have an opportunity if you didn't get something down or you had this brilliant idea about how we're going to move care coordination performance measures forward, that you'll have an opportunity to suggest that as well. Don, did

you want to say something?

CO-CHAIR CASEY: Well, I just want to say too that I'm -- I have to depart in about three minutes, because I have to make a board meeting tonight. But I agree with everything Gerri said and to Anne-Marie's last point, this is the chance to set the bar.

Anne-Marie, I don't know if there's a French term. There must be for that, but the French seem to have creativity as far as crystallizing in two words what we're trying to do in two sentences.

But in any event, I just want to say I'll be back on the phone. But thank you again for this, and I think we -- this is a really great accomplishment what we've done.

So I'm looking forward to the next phase of this, and getting this through the hoop, so we can get it out into the, into action, which is really what we need. So thank you again.

CO-CHAIR LAMB: Okay. We'll miss

you. Just a few words in terms of setting stage. Nothing terribly new, but just some beginning comments, and I think Will, you have a comment and then Eva and then we're going to go into work groups.

Just as a quick review, I think what you have up -- what is that? I can't read it. Oh, okay. Those are the questions. If we look at the past day, we reviewed 15 measures, okay?

Twelve of them we passed. Four of them were med rec. Three of them were transition record. Two were outcomes, one was timeliness of home care, and one was an advanced care plan, and I guess we tabled one, until we can look further at the survey.

So in terms of just kind of keeping the guiding frame that everyone, literally everyone here has been talking about is the value, upping the bar, pushing the field, getting beyond baby steps. We have all sorts of verbiage about how people have put that.

But the bottom line is what's important to measure, and what is going to advance care coordination and the outcomes associated with it? Some of the things that people have said is in terms of vision for the future, just to throw these out, is consistency across the care continuum, okay?

Don's reference to the hand shake. Eva's comment is that care coordination is in the intersections, and to recognize the players involved, physicians, nurses, social workers, the whole team. Where on that chain of activities do we want to emphasize and to also reduce box-checking, okay, make it meaningful.

And so let's just -- any other stage-setters, and then we're going to go into process. Will?

MEMBER FROHNA: I just had a comment. You know, the fact that we hadn't seen new measures put forward, kind of how do we encourage others from the outside, once we

set the bar of what we want, for them to participate and submit?

You know, obviously there's an expense, there's time, et cetera. How does that happen and especially since one of our consultants had something to mention about the reimbursement going down for whatever measure development.

And then the point about the medical home, you know, where there's a bigger universe of things out there that we don't even know about, that are -- sounds like Minnesota, Michigan are good, but don't come here?

So how do we -- I like that we set the bar, but how do we encourage everybody else to participate?

MS. McELVEEN: That's a good question. I can say from NQF's side is that we are striving to reach developers in a much broader sense.

So for example, we do have now

measure developer webinars, which are opportunities for people to be interacted with the updates on our process, to also keep them abreast on gaps, on information that's sort of ripe, if you will, to use that term, that they might be interested in.

We do have -- we have also implemented a new process that will allow someone who may have a measure that they're considering, but we don't have a project for it. They do have an opportunity to readily submit that information at any time to NQF.

So the purpose of that is to sort of create a pipeline and to make us aware of other areas for -- other areas of development that may be out there, but we just may not have a project to reach it currently.

So those are just two small examples of what we're doing. I know that there's, you know, it's something that we're continuing to strive to do better in.

MEMBER FROHNA: Have you seen an

interest so far in those efforts?

MS. McELVEEN: We have. I know that webinars happen on a monthly basis, might be bimonthly, but they have been very well attended, and we've gotten a lot of good feedback.

CO-CHAIR LAMB: Eva.

MEMBER POWELL: Thanks. Mine is just a very strict process question. From our recommendations, as part of this conversation, I would assume then that those would be part of whatever call for measures goes out in the future then?

CO-CHAIR LAMB: What would happen, and correct me if I'm wrong here, is that we would make recommendations. Those would go out for public review, and depending on the public review, that would go forward in the NQF process, and would expect that it would guide priorities for requests for measures in the future. Is that accurate? Yes.

MEMBER POWELL: Yes, and I guess

what I'm asking is not just guiding priorities, but also some level of specificity in the actual call for measures, not that I'm all familiar with what's in that. But I think that would be helpful in getting at what Will said.

CO-CHAIR LAMB: And with that, the need for specific recommendations will be, I think, very useful in driving that. So process-wise, is everybody had, been with your same work groups, have Preferred Practices?

If we could get into those groups and I think Rich, you're going to join us as well in that, and it's up to you as to whether you'd like to join a group, or whether you want to move around groups.

In your group, discuss your specific recommendation for measurement. Where do you think we should go? Are there new domains, okay, and if you would, have somebody be a documenter, so that we can get that down, as

well as a presenter.

And then how long do you think you need to do that? It is currently, what, 1:30? How long would you like to have that dialogue before we come back to a total group and have a discussion? What do you think is a reasonable amount of time?

Forty-five minutes, half an hour, 45 minutes, an hour? What do you want?

(Off mic comments.)

CO-CHAIR LAMB: You want to do a half hour and then kind of see where you're at, and then we'll go from there? And have somebody that you designate as your presenter, so that that person can summarize what your recommendations are, so that we can get it down and discuss and look for commonalities.

The product here is to be a list of where do we think the priorities should be? We don't need to rate them at this point. You'll have an opportunity to do that online. Let's just make sure that our list is

comprehensive in terms of what you think is important in upping the bar, moving this forward. Is that clear?

So half an hour. Then we'll go around and see where you're at, and then have a presenter. Yes. We can go into -- some of you can stay here if you wish. There's also the tables in that room.

(Off mic comments.)

MS. McELVEEN: We have flip charts that you want to use. The one other thing I wanted to mention is we have the practices as a starting point, for you to read through or to look at in detail, as a starting point for helping you sort of think of ideas.

You don't have to limit yourself to those practices in any way. I know the committee previously that endorsed that set of practices did really push the envelope, in terms of what they recommended, and so that's why we're using it as a starting document.

CO-CHAIR LAMB: And also feel free,

that if the domains that NQF is using for care coordination, the five domains, you think they should be expanded or we need new domains, by all means don't be limited by what exists.

Okay. So half an hour is about -- let's see. It's 1:30. Two o'clock we'll check in.

(Whereupon, the committee adjourned to discussion groups.)

Discussion Group Report Out

CO-CHAIR LAMB: Are we missing anybody that you know is coming back? Are we good? Okay. How about this plan? Is have each of the groups share their gaps priorities, and Lauralei's going to get them down, and take about say ten minutes to do that, and we'll have all three groups present, and then open it up for discussion.

The plan with this is we'll get our list down. It's not going to be perfect. We'll massage it a little bit and then get it back to you for prioritization and comments,

okay. So this is just a starting point, to get all our ideas down and get the wish list out for next steps.

Okay. So who's speaking for Group 1? Eva, you're speaking? Okay.

MEMBER POWELL: Thanks. I'll just reel off a list, and then if I miss something, my colleagues can jump in. We had a lot of discussion about operationalization of care coordination and what's missing there.

So we tended to focus on the concept of a care plan. But what we didn't focus on was we need a measure that says whether or not a care coordination -- a plan of are is in the chart. What we did focus on were the operational items of initiating the care plan, a transmission of the care plan, and let me clarify that.

By the care plan being a concept that contains a number of different tasks, roles, responsibilities, all of which would need to be defined. So initiation,

transmission, receipt and acknowledgment of receipt and acceptance of either the plan itself or a specific task.

Accountability, and there was a lot of discussion around that, and that that is an area that requires a lot of work and some real stakes in the ground from this group would be really helpful to a lot of people.

Then other things that we discussed were patient engagement in this whole process, and the notion of co-management of patient care for patients who needed that.

Let's see. What did I miss? There's also, and I think this would fall under patient engagement --

(Off mic comments.)

MEMBER POWELL: Co-management, sorry. Oh, I'm not even looking. Yes, that's correct. Let's see. So as part of -- sorry, patient engagement in the process, it was noted that a critical element of that would be language and health literacy issues, which is

veering off into a morass of other issues.

But I think the point, which was a good one, is that if patients who have particular needs with regard to language and literacy, if they do not understand their role in the whole care planning and care coordination process, then we've not coordinated care.

So they are part of it, and the health system needs to meet them where they are, in terms of being able to play that role. What else? This concept of a care plan has to be interoperable and longitudinal, as the other thing that we talked about.

And we described this in very much a future sense, of a technologically enabled health care system, which obviously we do not have today. But doing the things that are outlined in the care practices are not possible in our health care system today, so we felt okay in doing that.

But for, and the other point that

was made was that this is certainly far more than technology, and that is not the only answer, but that in this new system of the future that takes advantage of technology and all of its capabilities, that what we envision is a longitudinal interoperable care plan in the cloud, that every member of the care team has access to, including the patient and family, and that with the appropriate mechanisms and operational features that allow for sending and acceptance of various pieces of information, the negotiation of specific roles and responsibilities, as well as the documentation of that so that everyone knows what to expect, then that can be a real driver for quality measurement.

So have I missed something? Other people? Oh yes, and did I mention co-management? I think I left off co-management, the concept of co-management. Oh, it is. That's right. That was the code management.

No. The co-management is really an

important concept as well, because for many patients, that really is where it's at in terms of care coordination, that some will need, say the nephrologist, to be the health home, if you will, for a certain period of time, whereas others may require a different kind of provider to take that role. So I'll leave it at that. Yes.

(Off mic comment.)

CO-CHAIR LAMB: Can you put your mic on please? The structure of the care plan. Rich, come on up to the table. Join in. Jeff has left.

MEMBER POWELL: You're welcome.

CO-CHAIR LAMB: You get to be at the adult table now.

MEMBER POWELL: Well, I mentioned that our vision is that this is in the cloud, that it's accessible by all members of the care team. I don't know what -- did you have other --

DR. ANTONELLI: Well, you had

suggested some elements of what the care plan would be. So what the action items are, who's responsible, what the time frame is, what the expected outcomes might be, what I'd like to call what the contingencies are if you can't get that appointment in that time frame.

So it's a very clear road map that sets the stage for both the negotiation of accountability for the next step, as well as the ability to say okay, what am I committing to?

It's that lack of clarity about what I'm committing to that often leaves things in the lurch between generally subspecialists and PCPs, but it can be amongst any care team member.

MEMBER POWELL: Right, and with that, I'll emphasize something that's already been mentioned today, but it's extremely important to bear in mind that we're not just talking about primary care physicians and specialists, that obviously they are part of

this equation.

But that, at least from my experience, the vast majority of care coordination is not done by a physician. It's done by social workers, physical therapists, occupational therapists, a host of other individuals, and including, for certain people, people outside of the health care system, such as schools, certainly including behavioral health.

But I would include that and the concept of the health care system, but that we really are thinking very broadly about this, well beyond the walls of the health care system, and well beyond the physician degree.

CO-CHAIR LAMB: Other members of the work group, do you want to add anything?

MEMBER LEFTWICH: We did talk about the idea that data elements don't exist for some of the concepts that we have incorporated, and that we would hope we can actually drive those data elements being

defined and incorporated into the IT world because they're needed to enable this.

CO-CHAIR LAMB: Lauralei, you getting that one down? Okay, good. Well, we're putting up your name tags. Is this to comment on what's been recommended? Okay. And if we could kind of keep that, you know, to a couple and then we'll go to the next one, and then we'll have a group discussion. Chris?

MEMBER KLOTZ: I just had to respond to what Eva said about the bulk of care management being done by non-physicians, nurses and so on. The bulk of care management is done by patients and families, and I think we need to remember that.

MEMBER POWELL: But that's because we don't do it well though.

MEMBER KLOTZ: No. It's because we're not there all the time. You know even whatever, the best of systems. Unless they're in an institutional setting, patients

and families are managing their care the best they can, and we have to help them to do that in a better way.

MEMBER POWELL: They're the only constant.

CO-CHAIR LAMB: Just a point of clarification. Is it okay with everybody as people make comments, if it's not on the board, to add it? Like Chris is adding here patient and family.

Now the question here is the co-management. Is that specific to the plan of care, or is that a more general construct that you're looking at in your group?

MEMBER McNABNEY: I can give you an example. I mean it could go across -- when a person, a patient is in a particular setting, that there be less of an impact or less of a need even for transitions, if there's participation of all care team members.

So co-management, co-awareness, co-acknowledgment. It would be physicians,

family, other care team members would be the idea. But I think that co-management clinically, as Eva pointed out, is certainly part of it.

CO-CHAIR LAMB: Chris, do you want to put any concept up there, in terms of patient and family?

MEMBER KLOTZ: Well maybe it's related to the co-management topic as a subpoint, to just remember that it's, you know, the responsibilities the patient and family assume.

CO-CHAIR LAMB: Okay, great. Dana.

MEMBER ALEXANDER: Yes. One of the things we talked about in our group, and this is really kind of more of a logistics, just I think for NQF, is that a need for a glossary of terms. What came up, as we looked under our communication practice, I think it was Preferred Practice No. 12, talked about health care home team members.

Because I know I was confused about

what's health care home versus medical home. So we had some conversation going around about that. It's like that, there needs to be some definition around those two concepts, you know, the differences, if there are any, and then other terms as well.

MEMBER LEFTWICH: Yesterday it was inpatient facility. How do we define some of these things that keep getting re-used?

MEMBER LEE: I think when we drafted these comments, it's very much with the patient and family in mind, because while we were looking at most of the measures we reviewed today, that final part of acceptance and transmission of, you know, I got it, I understand it, it's not in most of the measures.

That falls into the patient level, the teach-back and others, is acknowledgment or the acceptance. So I think having those ideas in it, in communication domains at all levels makes sense.

CO-CHAIR LAMB: One thing we might consider doing, and this came up at the MAP Post-Acute Long Term Care, is having a domain of the patient's experience, and what's important to the patient and family related to care coordination.

What Chris has tipped off for me is with patients and families doing most of care coordination, what's the burden on them for this, and do we want to even put something forward, in terms of just thinking about for now what is that experience when you're trying to coordinate everything for your family member? Okay. Group 2.

MEMBER LYNN: That was a really, really fast hour. We had a great discussion. Our framing things under an umbrella of three concepts that have to do with formalizing shared care as a concept.

The first is a transactional element, that with information exchange, we would want to see measures that would look at

not just if information was sent, but also that it was received and that it was understood.

We also thought it would be important to look for and welcome measures that got at team awareness and a team orientation within practices, and we also felt that patient engagement was one of the most important things to be going after.

When we looked at -- we really only got through the health care home domain, with a couple of general comments on the proactive plan of care.

We thought that the first measure in the health care home domain that looks at whether or not patients have an opportunity to select a health care home, that felt more like a societal measure than something that was easier to get at at a provider level or a patient level.

Moving through some of the other measures, looking at the health care home as a

central point of care, we thought we would welcome measures from a patient experience perspective. So patient survey measures that could be triggered after some events, such as a hospitalization or an ER visit or a new challenge to the patient that was addressed by the plan of care, to look at how the patient is engaged and how the patient is understanding what should be happening next would be important.

We thought that a couple of the preferred practices, three and four, could be merged in a sense, in that they're looking at infrastructure for tracking shared care between the health care home and specialists, and would welcome measures that looked at things such as the appropriateness of referrals.

Was the request something that was appropriate and was the information that was received helpful to the referring physician. We also would like to see some measures that

got at whether or not the primary care provider and specialists have a documented structure, and if that structure was observed by both parties.

In terms of looking at care coordination for high risk patients, which is Preferred Practice No. 5, we felt that identifying patients was the first step, and then wondered if the principles of care coordination were really that different for these highest risk patients as they would be for others.

We also discussed it in this, that there needs to be the right kind of training for members of the team, and that that training needs to be updated, and there could be measures that address that. More globally, we thought that measuring the effectiveness of a team, whether or not it's a learning organization and whether they're functioning well as a team would be something that could be important to ask for.

And then when we were looking at some of the measures looking at the plan of care, we saw some nice examples listed, and wondered if some of these could be adapted from specific care of oncology patients or other specific conditions to something more general. So I'd ask others in our work group to make some comments.

MEMBER HOWE: Yes. I think we too had the sort of central discussion around the plan of care, and measure developers and/or NQF or professional societies to some extent, I think, have already sketched out what they think those structural elements are.

But I think a real fundamental is we need professional societies and societal agreement what is it? What is a plan of care? What are those structural elements, so that when you see one, you know what you're looking at.

MEMBER CARRILLO: And if I could just kind of emphasize something that we said,

it's that every measure that entails communication should have a corollary, just a question whether that there is a check that the communication was made, that it was received, and that it was understood, that it was registered.

That is something that should be generally applied to every practice that entails communication, because essentially care coordination is about communicating information to different parties, and that principle should be added to every measure that's developed.

CO-CHAIR LAMB: Suzanne.

MEMBER HEURTIN-ROBERTS: Excuse me. I want to get back to the team-ness. I would say it's not only team awareness but it's more like self-awareness, whether people are cognizant of the fact that they're part of a team and they're functioning that way, and also, some measures of communication among the team, and real communication, such that it's

transactional, that we know that there's not just communication, not just messages sent out, but there's knowledge being gained among the team, in terms of patients and plans, let's say.

CO-CHAIR LAMB: Tom.

MEMBER HOWE: Yes. One other thing that I think our team emphasized was there is an outcome here, an important outcome to get to the family and patient, and we would welcome, I think, measure developers coming up with a patient survey tool that would be able to address the adequacy or the functionality of the plan of care and its application by the care team.

And we could suggest some intervention points at which that survey might be appropriate, as in transition of care or, you know, a new diagnosis or a new facility impact. You know, it wouldn't be necessarily general, but you could focus on the high risk patients.

CO-CHAIR LAMB: Other comments? Questions for this group?

CO-CHAIR CASEY: Hey Gerri, it's Don. I just wanted you to know I've been on for a while. So I'm here. No comments.

CO-CHAIR LAMB: No comments? Okay. Let us know when you do, and Rich, go.

DR. ANTONELLI: So a couple of comments here. When I was privileged to be part of the group that put this together, I guess I'm sort of reviewing 9 and 10, just a few years hence.

I think a lot has been articulated about the so-called medical neighborhood, although maybe we can use the same construct and call it the health neighborhood now.

So I think the way Preferred Practice 9 is written is actually relatively weak. One of the things that I struggle with as a primary care provider is when I make referrals to the community that are vital for the patient and family, I can do everything

possible.

But getting that loop to close is extremely challenging, especially if it's a mental health referral. So I think to the degree that the National Quality Forum wants to set standards for care coordination, I'd like to see a bit more specificity in defining what those loops and linkages and interdependencies are for the so-called medical neighborhood.

On Preferred Practice 10, and I shared this with our group, so you guys please forgive me for my redundancy. So we talked specifically linking to a cardiovascular event. So while I don't like being too disease-specific, I do think that that kind of an approach is very meaningful for clinical delivery systems.

So I would even perhaps encourage us to sort of build out some opportunities around coordination of care across the continuum, for other types of quote "events," not just

cardiovascular ones. This could have profound implications for defining episodes of care, which is a hot button item for anybody who is thinking about how to refinance care.

Then the other thing is that, and I hope that the National Quality Forum staff will forgive me, but I am totally enamored of the cascade measures that have come out through the partnership, and even though at the last MAP meeting, somebody that was sitting in the seat that Chris is sitting in now, said they didn't like that term. Well, I'm going on record. I love the cascade measures.

DR. BURSTIN: Instead of families, which is the new term?

DR. ANTONELLI: What's that?

DR. BURSTIN: The new term for those sort of measures, the different levels of analysis from national down to individual provider is families of measures.

DR. ANTONELLI: Families, okay.

Families I like. I can deal with families, so I love that. So I think the opportunity to link the work of the NPP in the context of Preferred Practice 10, and you know, NQF staff may want to share with this group what those families of measures are.

That's the way to get the job done. The work that the Commonwealth Fund supported us a couple of years ago to define care coordination for children, built out potential measure domains from federal, national, state, community, delivery organization, PCP office and at the level of the family.

And guess what? Those measures are not the same. But from the patient's perspective, the outcomes can in fact be harmonized. So I would encourage the group to think about linking families of measures to Preferred Practice 10 more broadly.

Then you can throw stuff like depression, obesity, smoking, into that bucket.

CO-CHAIR CASEY: Gerri, can I jump in here?

CO-CHAIR LAMB: Go ahead, Don.

CO-CHAIR CASEY: Can you hear me okay? I'm on a noisy train, so I apologize for the interference. I want to echo Rich's sentiments, and I also want to caution us again about the use of jargon. I think we're getting wrapped up in patient-centered medical home, health care home, medical neighborhood.

I think what we need to do is to come up with a standard phrase or phrases that describe kind of the composite of this, because I think these jargon terms have different meanings to different people, since they haven't been standardized.

And that's why I think that the preferred practices were made to begin with, because now we're laying out kind of the spectrum. So I agree, that we need to make enhancements like Rich pointed out, around accessing resources and identifying

harmonization, as it's called, with some of the existing specific measures that can be embedded into the broader range of care coordination activities.

CO-CHAIR LAMB: Thanks Don. I think that's been a consistent theme, and I think Russ, you spoke to that as well, is we've got to have some standardized language, particularly when we're talking about settings. Any more comments or questions for Group 2? Tom?

MEMBER HOWE: Yes. Just to Rich's comments. As a measure developer objective, if the developers could come up with a referral relationship document, or the elements that would be in that document, and then measure whether that's present at the care team, home or at the receiving specialist's office, such that there's a formalized relationship that can be checked. Either it happened or it didn't happen as it was agreed upon.

CO-CHAIR LAMB: Rich, did you have another comment? No, okay. As to Lorna, some of the recorders have their notes on computer. Can you send those to Lauralei?

That way, we can check and balance that as well. Okay. Group 3.

MEMBER ALLER: The irony is the IT group has the notes on paper. So I'll see if I can lean over and do -- one of the themes -- all right, we had two domains: one was IT and the other was transitions of care.

So one of themes that we had was that we need to more effectively leverage the meaningful use program for quality measurement. So that hit in several different ways. One is that many of the meaningful use objectives and the measures that go with that are in fact transition of care measures.

But they're not specified as quality measures. They don't have consistent specifications. They're not endorsed. But things like percentage of patients who receive

a med rec document, percentage of patients who receive a transition of care document, who sign onto a PHR, those are very much related to the things we want to do, and our process measures we could tie into if they were effectively specified and endorsed and adopted.

A second component of leveraging meaningful use is that many of the measures we've looked at are wasting the measurement time on going through and saying did this transition of care record include this element and this element and that element, and then did the patient get it?

Well, if we specify that you're using a certified EHR and the certification requirement, as it's proposed, clearly specifies what's in that transition of care document. I'm not saying we specify what those certification requirements are; we leverage what's there.

Then we can focus on measurement

efforts, not on are all the elements there but how did we use those elements? Did we in fact deliver that transition of care document to the rest of the care team? Did we deliver it to the patient, etcetera, and did the patient use it?

A third element of that is that it enables us to move away from some of the surrogate data like checkboxes of, you know, did we do a med rec, to actually referencing the new med list that we can see in the record, that has the right elements on a given date. So we believe we could do a lot.

And some similar themes to what we heard from the rest of the group. We're really getting, using that clinical record, then, that electronic record to more effectively capture what are the critical patient and caregiver decisions that are relevant along the way, making sure those are captured in a standard way, and then they're used not only to support measures of adherence or outcome or

communication, but also have been linked to the relevant intervention.

So an example that, a couple of examples people gave were the patient's gave is to die at home. So if that's the patient's goal, how do we link that to the right interventions? How do we make sure, first of all, it's documented in a standard way? But then do we have measures that in fact compare was the patient's goal met? Did the patient want to attend their grandson's graduation? Okay, what did that mean in terms of care interventions?

A lot in terms of transition on care of patient-reported outcomes of did I get the follow-up care I needed? We specifically talked about having a four item teach-back measure, where the patient clearly understands their diagnosis, their new and changed meds, signs and symptoms, who to call. And again, those should be elements that are clearly a part of that certified health record, so that

we can then focus on did the patient understand them.

We also wanted care team or provider-reported outcomes. So did the provider perceive that they got the data they needed for the decisions they needed to make, and so we have that care transition document. Now does, did it in fact meet the need and did that provider get it?

Another component was measures that really bundle steps in the process with the desired outcomes, and then Alonzo in particular wanted to be able to use those, either mine the data across a large data set, to see how it differed for patients who did and did not receive steps and that use it to do controlled studies. If we follow one-- change one step in the process, does that change the outcome?

And I think -- we felt there was a real need for measures that assess whether follow-up activities occurred. We had one

example of those measures that we reviewed over the last two days. But in general, did the activities that needed to occur as follow-ups in fact occur? And do we have the data to support that?

Then the last one was said in that data set, we need -- there need to be better telehealth standards and guidelines, of what data are we capturing, how is it reported, who's accountable for that data?

Who's accountable for acting on it, and ideally having decision logic to provide notification parameters around that telehealth data? Did I -- are there things I missed?

CO-CHAIR LAMB: Comments from Group 3?

MEMBER FROHNA: Very nicely done. And I was going to say that the thing I think, we talked about the bundles, and I think like that exercise we went through around lunch time, I think to get to the really meaningful outcomes, death, the costs, readmissions,

those types of things, I think we're going to end up seeing more of these bundled measures, because once you try and cut out one of those things here, was that an effective measure?

Well, how can you tell, because there's a half dozen things that are a component to this. So that's, I think that's a real important piece that, like I said, I'm right along with Alonzo on that one.

MEMBER LEFTWICH: I would really caution against abrogating anything to meaningful use. I mean I think the objectives of meaningful use are right on target and align with what we say we think is important. But the thresholds for meaningful use -- well, two things. The thresholds for meaningful use are relatively low. We would want more transitions of care than meaningful use requires, to include these things, and we can't assure that if we don't double-check, if you will.

The second thing is from an on the

streets in Tennessee view of things, what the EHRs are supposed to be certified to do, they are not doing, and that may well extend to these data elements too.

The second thing, with respect to goals, we mentioned in our discussion, Group 1, about driving some data element development by what we need. I can promise you there are no data elements around the type of goals that we've talked about that are very much needed.

I want to dance at my daughter's wedding is not a unique data element, but it could well be somebody's number one goal. So we really need to drive development of some of those data elements as well.

MEMBER FOSTER: Well, I just wanted to reiterate that we talked a lot about the plan of care being a working document that the patient and caregiver can access, and right now it seems like they are kind of excluded from that.

And so this needs to be something

that it is longitudinal, but it's something they have access to, and then periodically the health care team assesses those goals, to see if they were a match.

I really think that, in the scheme of things, that's the most important thing for the patient. If we're really talking about a patient-centered plan of care, you know, it can certainly include the medical elements, but those have to tie back somehow to what is the patient's ultimate goal.

So I think if we can find a way to do that electronically, that would be ideal. But certainly having, I think patients having access and input to the plan of care is what we're missing now.

CO-CHAIR LAMB: Eva.

MEMBER POWELL: Thanks. I just wanted to emphasize what Russ said, just by letting folks know that the lack of measures and the lack of data is something that will absolutely prevent something from going into

meaningful use.

So that's an example of this group's, an opportunity that this group has, not just to advance practice, but certainly to advance policy, because if there's not an NQF-endorsed measure, you can be rest assured that it's not going to be a meaningful use.

CO-CHAIR LAMB: Alonzo.

MEMBER WHITE: I think an overreaching sort of theme that occurred in our group was that we really need to make a patient a partner in this, and give them a voice and the caregiver and family a voice in all of this, and not just focus on the providers and the institutions and all of the parts that sort of traditionally participate. I think that's what kind of lacking at this point.

CO-CHAIR LAMB: And Russ?

MEMBER LEFTWICH: One more footnote on meaningful use that everybody should be aware of. The certified EHRs have to be

certified to do all 25 functions that are the criteria.

However, the 44 clinical quality measures that are specified in meaningful use, those EHRs do not have to meet, and some of them, on the certification side, meet as few as nine of those 44 clinical quality measures. So just to be aware.

CO-CHAIR LAMB: Anne-Marie.

MEMBER AUDET: We also discussed a lot about getting away from surrogate measures and, you know, we've talked about this for the past two days. And perhaps in this area of care coordination, that when we were talking about getting more information from provider, did you get the information you needed to make a decision about the patient management on time from your colleague, and things like that, which are clearly lacking.

You know, there's always the burden of collecting survey data. But in fact, if you think about it, maybe there is a way of

getting out of that by if people are not talking to each other because they're just not getting into the care coordination activity, then we're not going to get any measures.

But if there's some activity and actually compact between people, then things will start to happen, and we will see that measure as a result of the actual activity, as opposed to having to rely on a surrogate or do a measurement of it.

CO-CHAIR LAMB: Don, do you have any comments?

(No response.)

CO-CHAIR LAMB: Okay. Maybe he'll come back to us and --

CO-CHAIR CASEY: I do not.

CO-CHAIR LAMB: You do not. Okay. You're still here. All right. So we've got quite a list, and let's just see if there's any other comments, if there's anything that you want to add to it.

It is now, what is it, three

o'clock, and I'm thinking that maybe what we want to do is given that this is probably what drives all of us and is where the passion lies in terms of pushing forward on this, to do a quick runaround.

This is not for pontification. It is more for if there's something that you really feel strongly about that has not been said, this is an opportunity. You'll have another opportunity more to do that.

What I'm anticipating is that we'll take this list, we'll take your notes and try to get it into a list that we can rate. We may do an interim step just to send it all out to you, because to make sure that the item is clear, so that when you actually rank it, we are all in agreement on what we're ranking.

But we've got a lot of different things here in terms of both content and methodologies, you know, methodologies being composite measures, families of measures, and we'll try and figure out a way to put that

back, so that we can have kind of a comprehensive recommendation.

So before we go around and just give you all a chance to say, you know, it's not up there and I think it's important, any other discussion, comments? Anything that anybody wants to share?

DR. BURSTIN: Just one question?

CO-CHAIR LAMB: Of course.

DR. BURSTIN: Maybe perhaps as people are going around, if you're aware of a measure like the one you're describing, that maybe is in use at some health system that's kind of IT savvy or somebody's thought of a creative way to do it, share that as well, because then that gives us information on who to go after next time for submission.

Not every measure has to be developed de novo by a measure developer. We love our developers, but we also think it's wonderful when we can pair them with folks on the ground, who have figured out how to do it

just for their health system. So with that friendly amendment.

CO-CHAIR LAMB: I do have a question for, I think it was the last group. You emphasized outcomes. Did you have any specific ones that you wanted to get up there, in terms of, you know, right now, the outcomes that we -- that are either, we're sending forward or are endorsed, are related to hospitalization and emergency room visits?

Are there outcomes that you specifically said that you believe we should be looking at from care coordination, from that group?

MEMBER FOSTER: I believe we talked about cost and mortality rates, along with rehospitalization, and Dr. White, do you remember anything else besides those? I know we --

MEMBER WHITE: No, and then just the usual admissions, readmissions. Karen?

MEMBER FARRIS: I had mentioned some

sort of functional status measure for people who were not in home care.

MEMBER WHITE: Right.

MEMBER FARRIS: I think we've got that in home care, but and that's going to only be maybe for certain types of discharges. But I think that could be really important.

CO-CHAIR LAMB: I also wondered if, you know, a lot of emphasis on patient experience and involvement, whether there was any discussion of quality of life as a performance measure.

MEMBER DORMAN: So we did talk about patient-reported outcomes, in terms of asking patients if the care was coordinated, so that they met their goals, and the outcome being their personal opinion as to whether or not it did meet their needs.

CO-CHAIR LAMB: So let's get that down as well. Any other general -- Emilio.

MEMBER CARRILLO: Yes. Both Group 2 and Group 3 paid attention to the issue of

teach-back, and I believe that NQF has a teach-back. I wouldn't know what to call it, whether it is a measure or practice, whether there is any measure within that practice, and if there is, should it become part of the constellation of the care coordination group?

CO-CHAIR LAMB: Anybody else, before we go around?

(No response.)

CO-CHAIR LAMB: Okay. We're going to do a quick go-around, in terms of this is a chance, and it's not your last chance, but a chance to just say, see this on the document so that we can consider it. So Chris, you want to start?

MEMBER KLOTZ: I can't think of anything to add that isn't up there.

MEMBER MALOUIN: So I'm not sure if this is what you're looking for, but I just want to say that I think the IT piece of this -- if we can use these measures to drive IT vendors to common measures, I think that would

be awesome.

What we're trying to do in Michigan is we're working with 500 different practices. They probably have 20 different IT systems, and what we're trying to figure out is how to measure care coordination, how to track care management activities, exactly the things that we're talking about here, and it's impossible because of the number of different systems.

So that's just the one thing I feel very strongly about, that I think we could really influence the health care.

CO-CHAIR LAMB: Just a question for Karen and Lauralei. When we started meeting, there was a white paper on IT implications for care coordination. Will that be part of the document that goes forward from this group?

MS. DORIAN: That's actually, that's up for public comment now through March 6th, and it is part of the final product, yes.

CO-CHAIR LAMB: So perhaps, Jean, that we'll have an opportunity to revisit that

as well. Russ?

MEMBER LEFTWICH: I may have missed that we got it up there, but we talked about having a care team roster with contact information in the patient's care plan record. The other thing, not something that would have been up there, but I think there's some low-hanging fruit on the communication.

There could well be measures analogous to the delivery of the document from the hospital or inpatient discharge, analogous measures for referrals to a specialist, and the specialist returning the document to the referring provider.

MEMBER WHITE: Yes, we also talked about contact information. We think that's a critical piece that's often missing, and the answer to every phone call shouldn't be go to the emergency room. So we felt very strongly about that. So I thank you for bringing that up.

The other thing that I just wanted

to go back to the telehealth issue, because that is becoming more and more important in the transitions area. There need to really be some standards and some automated processes involved, and some accountability there, because it's like the wild, wild west out there.

It's becoming an increasingly important part of our arsenals, and it needs to have some structure.

CO-CHAIR LAMB: Matt.

MEMBER McNABNEY: I think, I mean we talked in our group about the ideal of having transitionless care. But I think before that happens, I think, you know, having the transition language potentially, the hand-offs and the hand receipts, that would -- I think the immediate pushback from medical providers would be that a lot of that's burdensome or it would take too much time.

There might be an opportunity to stratify, have risk-adjusted transitions that

have different standards. So that if it's a more complex diagnosis or population like older people with multi-morbidity, for example, or younger people with neurologic or some other, where the risk of transitions is known to be at higher risk, that a higher standard and more involvement of hand-offs would be --

CO-CHAIR LAMB: Just a clarification. So intensity of hand-offs. How would you just frame that, in terms of --

MEMBER McNABNEY: So, I think, yes. So I hadn't thought it out, but for example, the giving of information and the receiving of information might be at a much more formal level, where the expectations were from this provider to that provider, from this -- if it was say maybe multi-disciplinary, where connections had to be made if they were at this higher level of risk transition.

But short of, I haven't thought through it that much. But I think you could

then, if you stratified it that way, you could at actually get people to do it and understand why you're doing it, as opposed to trying to apply it to all, where some transitions wouldn't be so risky.

CO-CHAIR LAMB: What that reminds me of is in the first go-round with care coordination, we had lots of debates about where to put, in the care coordination, case management. Case management is typically used for much higher risk, serious illness populations.

We made a decision not to separate them out, but it was kind of a placeholder. What I'm hearing is maybe a suggestion to revisit that, that there are subpopulations that are at much higher risk, and how do we handle their care coordination needs, and maybe address that. Is that fair?

MEMBER McNABNEY: Yes.

CO-CHAIR LAMB: Yes, okay. Jann?

MEMBER DORMAN: I would just like to

emphasize again the importance of patient-reported outcomes, and that care coordination is something that occurs in the eye of the beholder, and that unless we ask, we won't know how it's, you know, if and how it's being coordinated. So that's my --

I suspect that there's a corollary measurement domain in the patient-reported outcomes universe, that could align well with what we've discussed. And I don't know what others' experience has been with orienting to the stars and Health Outcome Survey.

In our organization, it's really had a transformative effect. It's really something that's where the measurement has really led the delivery system and the providers, to think about patients in a new way, and people are much more patient-centric every day, because they know patients are going to be asked how they think and feel about the care they got. So that's my plea.

CO-CHAIR LAMB: Linda.

MEMBER LINDEKE: Shared care plan that reflects joint decision-making with the patient and family would be the theme, and that would incorporate meaningful use, telehealth, and that patient engagement, patient experience that includes the family. You can tell I'm a pediatric provider.

CO-CHAIR LAMB: Thanks Linda.

MEMBER POWELL: I think we've got everything that I felt strongly about.

CO-CHAIR LAMB: Rich.

DR. ANTONELLI: I can always find something to say, but in fact I want to apologize ahead, because I need to get to the airport. But two things. One is AHRQ has this care coordination atlas, and in fact just within the last month, there's a new, a primary care version for that.

So I guess want to suggest the notion of harmonization around the thinking about care coordination, and I've actually found that atlas really nice, to sort of

structure the way I'm designing this system. But we should -- I would encourage the staff to do a cross-walk to that.

The other one that I struggle with, and I'm going to bring up payment, because my day job is as a medical director when I'm not seeing patients, is some measures around the financing aspect of that.

What prompted this, as I was preparing for the conversation about the medical home system survey this morning and the like, is I do think that we're going to find, in relatively short order, that there are certain types of payment models that facilitate, or at least support care coordination, especially the activity that occurs between visits and between sectors.

I would love for this body, and even more broadly the NQF, to be thinking about, you know, what are some measures that we want to be looking at, true systems of care that include funding mechanisms, and whether that's

a relationship between a so-called payer and the providers themselves, or the funding comes from the payer to the delivery system and ACO, if you will, and how those resources get allocated across the system of care.

So I guess I just want to make sure that people are keeping their eye on the ball around funding, because I actually think that that's part of why the tectonic plates are shifting right now, and thank you for letting me participate.

CO-CHAIR LAMB: Thanks for being here, Rich. It's great having you. Suzanne.

MEMBER HEURTIN-ROBERTS: I have two things. One, I'm concerned about patient burden. This is, you know, this is supposed to be patient-oriented care, and we keep having the urge to just go ask the patient. Well, there are some things that absolutely the patient needs to be consulted on.

But we shouldn't expect the patient to report upon things that perhaps could be

done just as easily, and perhaps more appropriately, by providers and provider systems. I just think that we're going to inundate people that we're supposed to be caring for, rather than, you know, they're not working for us. So just be mindful of that.

The other thing is I haven't heard us say anything about cultural competence. Please remember that, and especially in the context of Preferred Practice 9, which had to do with interaction with community and non-clinical services.

I would like to see cultural competence be expanded, not only to just interactions with the patient, but with communities and the health neighborhood, let's say.

CO-CHAIR LAMB: Anne-Marie.

MEMBER AUDET: I think I'll pass. I think I've, I don't have much more to add at this point.

CO-CHAIR LAMB: Karen.

MEMBER HOWE: Yeah. I will reinforce, I think, the importance of our getting a definition of what's in a care plan, that structural piece, and I do believe that since the outcome really is best perceived by the person having it, that we do need to incorporate that patient feedback somehow.

I think that you can structure the burden around incentives, either at the health plan level or some other way, to make people want to participate in this information exchange. There are various ways to do that.

And I think from the IT point of view, I just have a little anecdote I want to share, which everybody might cringe. But in darkest times when I was a student in Uganda, I was struck by the fact that people showed up to these bush clinics with a little piece of 4 by 7 paper, that had their contacts, what their medical problem was, what they were getting treated for.

It stayed with the patients. They

took it home. They were not seen in the clinic if they didn't show up with it, and it provided continuity in the most rudimentary society, you know, fabric. Where are we now, 40 years later, with the potential for a smart card that could capture every single element we're talking about, that would be transferable from place to place, and why is there no market for this?

MEMBER WHITE: The lawyers.

CO-CHAIR LAMB: Pam.

MEMBER FOSTER: This thought actually occurred to me yesterday, and I wish that I had spoken out when we were having a discussion about the home health, the timeliness of the home health, and it didn't occur to me until after we had voted on it.

But I guess I would encourage everyone to keep in mind, when we're, you know, putting time limits and things like that, that the rural health population is completely different. And you know, I don't

want an unintended consequence of that home health measure to be that well, we can't meet that, so we won't put the patient on service.

Now we've just, you know, denied this patient home health care. And you know in the rural setting, one single provider may be the medical home, may be the community-based organization, may be everything to that patient, and the community-based organization may be the church, it may be the neighbor.

I think just we may need to think about exceptions for that population. I just wanted to put that out there, because it occurred to me and I guess that I wish I had spoken up yesterday, but you know.

CO-CHAIR CASEY: Hey Gerri?

CO-CHAIR LAMB: Yeah Don.

CO-CHAIR CASEY: I'm losing my track in following the sort of conversation here. It seems like there are a lot of good ideas, but it doesn't seem to be focused back on the preferred practices. I know that there's, for

example, sensitivity to cultural competency.

There are specific statements in the details talking about that, and I thought that what we wanted to do was to use it as a framework for specific measures, which I think we've done. Also to decide how we're going to either change or enhance, which I think we made recommendations.

I think the other point was could these -- could this be a checklist? I'm not sure it would be maybe the NCQA care coordination standards, but you know, maybe it could be. I'm just trying to get at moving from lots of discussion to kind of how do we actually use the preferred practices going forward, to you know, we've already talked about informing policy, pointing to measures.

But how do they help organizations or communities actually improve, given that we've got positive measures? That's kind of the part that I'm hoping we get to in the discussion that's left.

CO-CHAIR LAMB: Okay. How about, Don, if we just finish with, there's only three more people who have a chance to share anything, and then if you would like to -- let me reframe that, so I'm clear that we're discussing what you'd like, is taking the preferred practices, which each of the groups started with, and came up with focus areas, whether it be in plan of care, patient experience and goals.

How to translate that into, I'm thinking we already did performance measures. So maybe I just don't understand the direction that you'd like the conversation to go.

CO-CHAIR CASEY: Well, I think we had talked before, you and I with staff about trying to turn the preferred practices into something that can actually be used in the field. I think that was kind of the other part of this conversation, that we wanted to think about.

One idea was to create maybe a checklist or a readiness assessment. That's not what NQF does, but that's something we could think about.

CO-CHAIR LAMB: I see.

CO-CHAIR CASEY: We have other preferred practice statements like safe practices, which are not measures. They contain measures, but they're not measures, but when put together constitute the top priorities for the organizational approach to patient safety.

We have the same thing for palliative care, and Nicole is working on cultural competency, because there aren't a lot of measures there. So I'm just trying to see if anyone thinks that it's useful to make the enhancements that we've suggested, and then do the same sort of thing here.

My concern all along is that I don't think preferred practices got much light of day, and I don't think people are aware of

those, and just through looking at the summary statement, which isn't really -- which is a pretty shallow explanation of what the work that you and I, and Chris and Rich did before.

CO-CHAIR LAMB: I'm wondering if this would be acceptable, Don. In the interest of time, I think what we've all generated is ideas for next step performance measures, and what we can do perhaps in the survey is ask the question about what are other uses for the preferred practices that we can move into, and generate ideas that way, because we're beginning to lose folks.

I'm thinking that what we can do is generate the list of performance measures, and then use the survey to generate some additional ideas. How would that be?

CO-CHAIR CASEY: Well, I think that's fine.

CO-CHAIR LAMB: Okay, all right. So let's finish with Will and Kathleen and Emilio, and then we're going to kind of pull

it together. Oh, Lorna. Forget Lorna. We don't want to include Lorna anymore. Go ahead, Lorna. Sorry.

MEMBER LYNN: So two thoughts that I'd like to share is that I wonder if we need to be moving towards thinking of a new type of composite. So an example we had in our group was a biopsy measure that looks to the biopsying physician to deliver the information about it.

Did the primary care physician receive it? And did the patient understand it? So that this would be a new way of thinking about a composite measure that might be very applicable to the whole idea of care coordination.

The other thought is that I think we need to be comfortable with the idea of measuring others and receiving feedback from others in a formal way, so that you know whether or not you provided a useful consultation.

You know, whether or not you gave the consulting physician the information that she needed to provide in a useful consultation. Those are my two thoughts.

MEMBER ALLER: Just a brief follow-up, and in deference to Don, I will say this would be related to Preferred Practice 15: standardized, integrated, interoperable information systems.

In addition to the physician and hospital systems that we've talked a lot about, and physician and hospital measures, is that real need to incent health records and interoperable, integrated systems way beyond those settings of care. We talked about that some in the paper, but I think it's a huge gap.

CO-CHAIR LAMB: Emilio?

MEMBER CARRILLO: Just to reflect back on what Suzanne and Lorna pointed out, this triple attention to it was sent, it was received and it was captured and understood,

speaks to cultural competence, because you know, linguistically and also culturally, the barriers in communication are the patient may just sit there and just say nod their heads, yes, yes, yes.

But this will bring out when there is no -- there's no reception of what the message that you have brought forth. One last thing is that again, we'll do a lot more work and thinking around the complicated issue of the NCQA, patient at the medical home ideas.

But I think that it would make sense for us to just do a cross-walk, you know. How do our practices cross-walk to NCQA, like Jean said, like to URAC, to the New York State Health Home Project, which is all about the complicated care management of patients, etcetera.

So I think that whether or not we agree with them or not, or whether we adopt or not, I think that cross-walking, just to see what's out there and how they relate, align

with what we have, would be a good exercise.

CO-CHAIR LAMB: Thank you all. Anne-Marie, final comment on this, and then we're going to call it a day.

MEMBER AUDET: Sorry, now I have something to say, and it's because of Don's comment about what we can do with preferred practices. One thing that struck me in a lot of our discussion is that these could actually guide the development of best practices, because they're really high level principles.

The patient shall provide information to select the health care home. But there must be some best practice about how you can do this. So it would lead to actions, and it would lead to development of these best practices, that could then drive us towards more measurement of this.

CO-CHAIR LAMB: Thank you. Eva, do you have a dying comment here?

MEMBER POWELL: Yes.

CO-CHAIR CASEY: Thank you.

MEMBER POWELL: Just a very quick one, also prompted by Don's comment. But it strikes me, and maybe this is just me finally clueing in, but most of care coordination, I think, is centered on an individual patient.

But it strikes me that there are some important ties to population management as well, and I think we shouldn't lose that in there. Not every preferred practice is this way, but for example Preferred Practice 5 and 10 show some clear opportunities to bring in the population health, kind of per the cascading family of measures idea.

CO-CHAIR LAMB: I think if we had another day, we could spend another day on this at a very, you know, at the minimum. What we're going to do now is turn it over to Lauralei for next steps. In this piece, I think we generated a list of, I can't even see how many, pages.

So the next step on this work is to perhaps try and get some intuitive groupings,

and put it out to you all, and make sure that it captures what the intention was.

Then we'll go forward, similar to what's been done with some of the other work groups on rating them and prioritizing them, and also addressing Don's question of what else could we be doing with preferred practices, because we have this group of 25 very rich practices, and we've only just begun to touch that. So Lauralei?

Next Steps/Time line For Project

MS. McELVEEN: I just wanted to make one comment quickly, is that many of the members here spoke a lot about communication, health literacy, cultural competency. I wanted to assure the group that we're striving to get there.

I'm currently managing a project on health care disparities and cultural competency, and we just had our in-person meeting Thursday and Friday. Some of the measures that we're considering are:

addressing cross-cultural communication, language services, whether patients are receiving interpreter services from a qualified health care professional.

We also have gotten two measures from the CAHPS item set around health literacy and cultural competency. So we're getting there, but obviously that's, you know, a critical area, because you all have mentioned it and we're also looking at measures in that area.

We also have a project around population health, where we're starting to, you know, we're starting to branch out on areas that are more cross-cutting and areas that are obviously very important.

MS. DORIAN: All right. Thank you, everyone. I don't know about you, but I've had a really good time these last two days, so thanks for your participation. Just a few quick notes about next steps.

Coming out of these two days, we do

have two, potentially three conference calls. We have the one to review the composite, the NCQA composite measures, so we'll schedule that quickly, and then also the conference call to review the related and competing measures. So we'll work on scheduling those as quickly as possible so everybody can participate.

After that, we will work on drafting a report, which then goes online with the measure forms for public and member comments, and then just in terms of the time line for that, the NQF member and public commenting period lasts for 30 days.

So that's scheduled for April 2nd through May 1st, and then we do have a Steering Committee conference call. We haven't scheduled that yet, but it will be some time from May 16th to May 21st, and that's when we sort of talk through those comments with you, and we look at the comments that are measure-specific, like you know, why

was this measure specified at this level, etcetera, that those go to the developers.

But then there may be some policy questions that go to NQF, and then there may be some questions for the Steering Committee, like why didn't you consider this? So we'll have a conference call to discuss that.

Then the NQF member voting period lasts for 15 days. We do have a pre-voting webinar, which you're all welcome to join. That's sort of for our members and the public, where we just briefly overview the project and the overarching issues, and the comments that came in.

So we'll hope that Don and Gerri will be on that call, but of course everyone else is welcome, and then it continues on to CSAC review, board ratifications and the appeals and final report, which is expected to be completed in August. So that's kind of just --

CO-CHAIR LAMB: Lauralei, just a

quick question.

MS. DORIAN: Yes.

CO-CHAIR LAMB: In terms of the survey that we need to revisit--

MS. DORIAN: Yes.

CO-CHAIR LAMB: --we had talked about having a small work group go through the specs and make some recommendations, and then have, you know, either do it on survey.

You had a phone call up there. Were you thinking it was going to be everybody, or are we going to get a small work group together first?

MS. DORIAN: Are you talking about the medical home system survey?

CO-CHAIR LAMB: Yes. I thought we were going to do that in a small group, with some folks and --

(Off mic comments.)

CO-CHAIR LAMB: And maybe what we can do is it sounds like everybody wants to be involved in it. What if we get a small group

together, to really look in detail at the specs and raise any issues, and then got everybody together, so that we weren't trying to all do that kind of level of detail together?

For those folks who really want to do that 120-page detail, that's what it's going to take. So but everybody will be involved in the thinking and the decision-making, but there is that first step of detail work that needs to happen pretty quickly.

So I was thinking we'd have a small work group together for that first.

MS. DORIAN: That sounds good, and if you could email me if you're volunteering to be a part of that group.

CO-CHAIR LAMB: Just raise hands, the detailed spec work?

(Show of hands.)

MS. DORIAN: Eva, is that a yes? Okay. Can you raise your hands one more time?

(Show of hands.)

CO-CHAIR LAMB: Great, okay, and then --

CO-CHAIR CASEY: I'm raising my hand.

CO-CHAIR LAMB: We just assumed that one, Don. And then the other piece was this list, and maybe figuring out how to get that back out, and I think some of the groups that you've worked with Nicole, and I know MAP has done this very efficiently, like in the course of a week.

So I'm sure there's a tremendous amount of work going on behind the scenes, but you can guide us on that as well. Any questions about next steps? I'm not going to ask for final comments, because I have this feeling everybody's going to have one.

Just one from all of us and Don, on the train, thank you so much for all the work that you did in preparation for the intensity of the work in the last two days. I'm very excited about the recommendations that we're

making, in terms of new types of measures, getting that handshake solidified, the IT work.

And I think it's really important to be able to move those kinds of recommendations forward. So thank you for all your work. It's not done yet, so we've got some conference calls and some work ahead. But thanks for this two days, and have a safe trip home. Don, do you have any final comments?

CO-CHAIR CASEY: Safe travels home, and may your voyage be coordinated.

(Laughter.)

CO-CHAIR LAMB: Very nice.

CO-CHAIR CASEY: Take care.

CO-CHAIR LAMB: And leave your voting things. Don't take those home.

MEMBER DORIAN: So this has been a wonderful meeting. It's been so well-staffed and so well-coordinated that it was just immensely productive. So thanks for everyone.

(Applause.)

(Whereupon, the above-entitled matter went off the record at 3:40 p.m.)