

NATIONAL QUALITY FORUM

Moderator: Lauralei Dorian
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1:00 pm CT

Operator: Welcome everyone to the conference. Please note today's call is being recorded. Please stand by.

Lauralei Dorian: Thank you. Good afternoon everybody; welcome to the Workgroup Call today. This is Lauralei Dorian and I have with me Karen Johnson and Evan Williamson from NQF. And before we get started I'm just going to do a brief role call to make sure we know who we have on the call today.

Don, you're there, right?

Don Casey: Yes I am.

Lauralei Dorian: Right, okay. Dana Alexander?

Dana Alexander: Yes I'm here, thank you.

Lauralei Dorian: Great, James Lee?

James Lee: Yes, I'm here. Good morning.

Lauralei Dorian: Good morning. Russell Leftwich?

Russell Leftwich: Hi, I'm here.

Lauralei Dorian: All right, Matt McNabney?

Matt McNabney: Here.

Lauralei Dorian: Eva?

Eva Powell: Here.

Lauralei Dorian: (Denise)? Okay, Jeffrey Greenberg?

Jeffrey Greenberg: Yes, I'm here.

Lauralei Dorian: And Jean?

Jean Malouin: I'm here too.

Lauralei Dorian: Perfect and then I'm just going to check to see who we have from the developer's side
as well. PCPI folks?

Robert Palmer: Bob Palmer.

Lauralei Dorian: Okay.

Female: And this is staff at the PCPI, we're on the line as well.

Lauralei Dorian: Okay, great. And anybody from CMS or Acumen?

Female: Acumen's here.

Lauralei Dorian: Great and NCQA?

Female: Yes, NCQA is here.

Lauralei Dorian: Okay, good. Seems like we have everybody on board. I'm just going to hand it over to Karen Johnson right now and she'll just go over some of the details of the call today with you.

Karen Johnson: Thank you, Lauralei. I just wanted to start out by again thanking everybody for doing those preliminary evaluations and for taking the call today. And let me describe the process of how we'll go through these measures. First of all, I'm sure you know that we had asked several of you to be the lead discussants for a measure.

So just to remind you as the lead discussant, we'll ask you to summarize the measure and then summarize the rating and the rationale that came up in the preliminary evaluation. And for that, you know, be as detailed as you need to be, but you don't need to go through every single comment. You might be able to just summarize some of those comments.

But definitely highlight areas of concern and areas of difference that came up as people evaluated the different measures. After the summary, we'll first open it up for steering committee members to make comments either further describing some of the questions that they may have had and then just going onto general workgroup discussion of the measure.

And as you know, the developers are also on the call. So that would be a time there if you have specific questions that you would like to address to the developers. You could do that then and hopefully they would be able to answer any of your concerns about the measures.

We have about an hour and a half roughly to go through all of these measures and since we have six measures today that we're going to get through, that gives us roughly about 15 minutes per measure. So it's not a lot of time. But the caveat there is there are four PCPI measures and they are very similar in many ways.

So what may happen if this is how the call goes is we may end spending a little bit more time on the first PCPI measure and it could be that the other PCPI measures may not take so long. So we won't be as kind of strict on the time on that first one. Just to give you a reminder of what we at NQF staff are here for, we're here to clarify if necessary any of the NQF criteria or guidance.

And yesterday we also had to kind of mind the clock. But today we're fortunate enough to have Dawn on the line. So I think Dawn is probably going to be able to move the call along and all that sort of thing and we'll only jump in if we just absolutely have to on that one. So we're pretty much going to hand it over to Dawn here in just a minute.

And just so you know, Heidi just was able to join us. So we have her expertise in here as well if we get stuck. And then finally, one final reminder. If the discussion really gets rolling and we do run out of time, I just wanted to remind you that we do have the discussion forum that is available to you on our SharePoint site.

So see if you have - if you want to continue a conversation about a measure between yourselves, then you can certainly do that on the SharePoint site. So with that...

Lauralei Dorian: I just - also just two more quick things to note. The call is open to the public today so we'll be having some public comment towards the end of the call. And also please keep your phones on mute if you're not here.

Karen Johnson: Okay, so with that I'll hand it over I think to Don and then Don we had asked (Steve) to introduce our first measure 0646.

Don Casey: That sounds good.

Eva Powell: This is Eva, I'm sorry to interrupt. How would we know if we were the discussant? I'm sorry; I've not been able to figure that out.

Karen Johnson: Oh...

Eva Powell: Should we have been contacted separately I guess is my question?

Karen Johnson: No, it came in a briefing memo when we sent out instructions on how to do these evaluations. So in a table that had the workgroup call and the measures listed for the different calls, basically if you had a highlighted measure beside your name then that was how we tagged you to be the discussant.

And Eva we had tagged you to be a discussant, but if you're not comfortable doing that then I'm sure either someone else could take over or if necessary I could do it too, so.

Eva Powell: I mean, I'm happy to do it. I just didn't see where that was, so.

Karen Johnson: Okay.

Don Casey: Why don't we - how about as a reminder, do we want to list out since there are six, just list out the names of each individual measure so that we're all on the same page? Can we do that ahead of time?

Female: Yes, sure. Yes.

Karen Johnson: You mean as we go or at the beginning?

Don Casey: Why don't we do that right now so that everyone is on the same page?

Karen Johnson: Okay.

Don Casey: Just take down the list.

Karen Johnson: Again, Lauralei is bringing up the agenda too so if you can see this on the webinar you'll be able to follow it here. The first measure is 0646; it's a PCPI measure, Reconciled Medication List Received by Discharged Patients. And then 0647, Transition Record with Specified Elements Received by all Discharged Patients.

Don Casey: Right and just tell us who the lead is on each of those.

Karen Johnson: Oh, I'm sorry. Okay, 0646 is James.

Don Casey: Great.

Karen Johnson: 0647 is Russell and then 0648 is Timely Transmission of Transition Record. That's Eva if she cares to do it.

Eva Powell: Okay.

Karen Johnson: 0649, Transition Record with Specified Elements Received by Discharged Patients.

That's (Denise). Is (Denise) on the line?

Female: (Denise), are you there?

Don Casey: I don't see her on the attendee list.

Karen Johnson: Okay, so we might have to have help on that one too. Okay, 0520 is a CMS measure,
Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episodes of
Care. Dana Alexander.

And then finally, 0326 NCQA measure Advance Care Plan and that's Matthew McNabney.

Don Casey: So for the five who are on the call, are you all set to - is anyone not set to sort of help lead
the discussion? Eva, I know you're going to look at yours, but...

Eva Powell: Yes, I'll take a look as I'm listening to your conversation about the others, then it should be
fine.

Don Casey: Okay, so are the other five comfortable with moving ahead?

Dana Alexander: This is Dana Alexander; I'm somewhat in the same boat as Eva. I just discovered about
ten minutes before the call that I had a lead assignment, but hopefully by the time you get to me
I'll be rearing to go.

James Lee: This is James Lee; I'm comfortable leading the discussion for the measure.

Don Casey: That's great, anyone feeling uncomfortable? Well then why don't we jump into that and James, since you're at the top, why don't you lead us through 0646. And I would assume that we would also have the measure spec up on our screen share.

James Lee: And so I apologize for the webinar through the secure portal. For some reason it's blocked from my end so I will have audio only in terms of information. So in regards to 0646, Reconciled Medication List Received by Discharged Patients. After reviewing member's feedback, overall I think all of us felt that this is a high impact measure in that the impractical day to day works.

The reconciliation exists in our day to day work in clinical arena. There's also a sense that when it's done correctly, consumers benefit from this reconciliation and that the literature that was provided on our portal looking at pharmacy reviewed medication as well as the Australian VA looking at sub-populations suggest that a medication review is effective.

The concerns that come up is that literature really suggests many of the reviews are done in a home setting as Australian VA article and (Eric Coleman) transition model pointed out. There was significant concern about denominator or we base the denominator on patients versus hospitalization events which are the targeted sub-population that this measure can be applied to.

And what are the scientific acceptability. There was some mixed feelings about usability based on the comments and that there's also mixed feelings about whether this measure meet the criteria to be endorsed under National Quality Forum current standard.

And with that, I'll open it up to the forum and see what everybody thinks about this.

Robert Palmer: This is Bob Palmer. First of all, I apologize that I have to leave the conference call a bit early to teach a class here at Eastern Virginia Medical School. I will have to leave at about 2:45,

but I can briefly comment on some of those issues and concerns that were raised. First of all, there is a growing body of evidence in the literature that medication reconciliation is a serious issue across the continuum of care.

So from hospitals to skilled nursing facilities and vice versa, skilled nursing facilities to hospitals, but also to home care. So literature suggests that numerous errors are made in correct medication doses and medications are being listed as current medications. And in some cases patients medications that were discontinued or held during their inpatient stay are not being resumed when patients either transfer to an inpatient facility or return home.

So the literature continues to show that this is a serious health problem across the care continuum and it's particularly an issue for elderly patients because first of all they are more likely to have multiple chronic conditions and are more likely to require polypharmacy for those various treatments. So first of all, it's still a significant issue across the continuum and it's both a quality of care issue in that patients are not always getting the appropriate dose.

But it's also a patient safety issue in that needed medications are either forgotten about, not discontinued or are continued in the face of an adverse reaction or adverse effect. So we - I was Co-Chair of the workgroup for the care transitions measures with (Mark William).

We had lengthy discussions as a group about this and we felt that - we knew that medication reconciliation was probably the most challenging of all safety issues particularly among the National Patient Safety Goals of the Joint Commission. And we recognize that we needed to be very practical in establishing our measures and to be parsimonious in our requirements for the numerator instruction.

We felt that being able to inform patients and post-care providers about medications to be taken by the patient, those that would be continued or those that would be new was essential. And also

essential was to list medications that were not to be taken by the patient specifically those that were discontinued or for which there were allergic reactions.

My point really is that this is a common problem in all adults who are being transitioned from an inpatient facility. It isn't limited to geriatric patients even though the older and chronically ill patients are at the greatest risk of safety and quality issue. I'd be happy to answer any questions that anyone has about our thinking and our reasons for selecting the numerators that we did.

Don Casey: So Robert, this is Don, I think you've really focused on the first part of the measure description which is the importance to measure in report. And you mentioned briefly the evidence. Can you comment on the other domains of the measure such as the scientific acceptability, usability and feasibility? Because those are also important elements of the decision making of the group here.

Robert Palmer: Right, just commenting about the feasibility, the issue really that we reviewed was whether this information about medication and reconciliation could be determined from a chart review through - in some objective way.

And we felt that given the importance of drug prescribing and hence the need for reconciliation, this was standard practice that there should be documentation in medical records of medications baseline meaning prior to the admission to the facility and any adverse reactions that would occur and at the time of transition a listing of the drugs.

So we felt that this could be obtained through chart review, that it would be feasible to do in all adult patients in 50 states and that very certainly it would be a reflection of the quality of care and the need for documentation. I'm sorry; I forgot already the first question you asked me about.

Don Casey: Well, it had to do with the other domains of the measure specs, so you did address feasibility.

Robert Palmer: Yes.

Don Casey: So that's important feedback. Any questions for Robert or other comments on what James presented?

Jeffrey Greenberg: Hey, this is Jeff Greenberg. I couldn't agree more that this is like a hugely critical issue. I think the feasibility is questionable I think - I don't know that there's a whole lot we can do. I mean, just asking people to do chart reviews is not ideal. I would hope that any EMR would be able to provide these data without having a strategy on manually abstract charts.

But my question actually on the reliability and it relates to both this and I think you had another measure too that were also from the PCPI program.

So I'm sort of new to the sort of scientific side of this, but my sense of the reliability testing would be I'd want to be confident that if one person looks at a chart to determine whether this metric was met and another person looks at the chart independently and they're going to come to the same conclusion yes or no. And maybe I'm missing it, but I'm not seeing that that kind of test was done.

It sounds like you compared it to an EHR to manual abstraction, but I guess I'd be concerned that this is going to rely on manual, you know, on human beings abstracting a chart. We want to make sure that it's sort of clear when the measure's met and not two totally different people would come to the same conclusion, you know, most or all of the time.

Don Casey: So would part of this concern be the inter-rater reliability?

Jeffrey Greenberg: Yes, that's exactly what I'm saying. Yes.

Don Casey: Yes, yes.

Jeffrey Greenberg: And it may be these are long documents and it's entirely possible it's in there and I missed it, but I just wanted to see if you thought about that or that had been done.

Joanne Cuny: This is Joanne Cuny from PCPI. I want to make sure you can hear me.

Jeffrey Greenberg: Yes, I can.

Joanne Cuny: Hi, okay. Hi and so this measure, the reliability that you're seeing here and just as you described it was more along the lines of parallel forms reliability comparing an abstractor constructing the measure manually to an EHR generated report. So the way that this is pretty much classic testing for the reliability of an EHR generated report.

So in this particular project that we did for this measure, we did not do inter-rater reliability. What the thinking is and I know Heidi and others from the NQF are there as well, but this type of reliability is to confirm or assure in some way that if we asked an EHR to generate a performance score for an institution or a physician or whatever level, that we could confirm or that we could find it reliable that that was giving a true performance which is why we do parallel forms.

So in other words, at a site and this is just EHR testing that was done from this particular site. At this site that organization had their IT folks program their EHR to capture all the discreet fields in their EHR where these data elements were captured. And then to program the logic so that those data elements would interact to produce a performance score for a time period for the patients that met the criteria during that time period.

And after a report like that is generated, it's actually generated in a table so that all the patients that contributed to that score are captured within this table which allows us then to select a randomized sampling of patients within that time period that produce the score so that a manual abstractor can then go in and look within the EHR throughout the entire EHR for that patient to look for those data elements to manually construct a measure.

Without - they don't need to be - they can be blinded I should say as to whether or not the report says whether or not that patient hits the numerator or not or if they're designated as an exclusion or an exception or not. The manual abstractor just simply looks at the patients within the sample and says for themselves whether or not this patients meets all criteria for the denominator, meets the criteria for the numerator or not or looks like they would be an exception to the measure.

And then the parallel forms reliability is conducted to say how well the manually generated score aligns with the EHR report. And that is the agreement rate that we look at.

We did not do inter-rater reliability in this particular project and we could - we don't always do inter-rater reliability when we're doing EHR testing because we feel that if the EHR can say that this, you know, had generated or programmed their EHR to generate this score, that the data are there. They have to be there in order to generate the scores, so.

Jeffrey Greenberg: And that makes a lot of sense and we do very similar kinds of quality checking internally. I'm at Brigham and Women's Hospital, we do a lot of the same thing when we use our EHR and electronic means to measure, you know, various metrics. Do you have a sense of are most people going to be using this or have been using this with an EHR or are actually doing manual abstraction for the sake of this measurement?

Joanne Cuny: We have in the site that we chose to do this, they're aggressively going - I'm sorry, I just swallowed a glass of water...

Jeffrey Greenberg: That's all right.

Joanne Cuny: ...and I thought it was all the way down and it was stuck in my throat. There are some organizations and we have other sites here from the (Highmark) Center organization that are under (Highmark) which is a plan in Pennsylvania that have various forms of data modalities where they are all attempting to achieve excellence and performance on these measures.

And they're also including in the testing where the scientific acceptability section of this submission. We did not use them for reliability testing here because we - they did this aside from the PCPI. They just reported to us on how they were achieving their expected goals over time. And I am only saying this because I know that some of them have - do not yet have EHR's that are on paper charts at this point.

I would say that it makes sense that it will be much easier and more feasible to collect this - I mean, less of a burden let me say as we go forward and all measures are programmed into EHR's.

Male: Absolutely and then Joanne, I'm sorry to interrupt here. I appreciate the input and I don't want to disrupt the conversation Robert, but I do want to point out that on the screen share there is - the staff have put up the results of a percent agreement. It looks like it was tested by (Kappa) showing about a 91% overall agreement which is pretty high.

Joanne Cuny: Yes, that's accurate.

Heidi Bossley: Don, this is Heidi.

Don Casey: In the measured spec here it looks like we've got some background here.

Male: And I certainly saw that Don, that's looking at the EHR to manual abstraction reliability. So I guess I have two questions from this. One is, you know, are we concerned in terms of for are people going to be using this without EHR's and through the manual abstraction? Do we need to be convinced that it's sort of an obvious tool that the inter-rater reliability can be high?

And then a broader question I have is do you test this with one EHR? There are obviously hundreds of EHR companies out there. Whose job is it to make sure that they're reporting reliable metrics? I mean, clearly not yours. I mean, clearly not PCPI's, but how do we know that every different EHR is going to pull the data in the right way? Are they expected to do some kind of quality check in order to be able to submit or?

Don Casey: Let me ask if we can be brief with this because I want to be sure that the members of the sub-group on the committee actually spend the bulk of the time discussing this, so. Could you clarify that ((inaudible))?

Heidi Bossley: This is Heidi; can I give a little indirect perspective on a couple things there?

Male: Sure.

Heidi Bossley: Okay, so just a couple things here. So we're looking through the reliability section, but we need to go back and look at our criteria and we had a task force in the last I'd say year and a half ago go back and look at exactly what we would define as reliability testing and validity testing. What they presented here when you look back at that task force recommendation is really validity testing.

And in that task force we can pull and send around because I think this is something that's going to come up through the rest of the measure so we'll send it around to the workgroup and the full committee after this. Validity for EHR can be done in two ways, what you see here is one of the ways that it's consistent with what that committee had recommended.

So we have again I think PCPI as reliability, we at NQF see it as validity testing. And I think a question for the committee here is, is that adequate results that you see here for that? On the question of whether it should be used for a paper medical record, I think we need to have an offline discussion just as staff and the committee should weigh in on this as well as because they haven't provided testing for the paper record, is it appropriate to put that measure forward using that data source?

And I think that's something the workgroup should weigh in on and we should talk to PCPI about. And then going to the question about is just one EHR and that's just one EHR, that's an issue that we're looking at right now.

Male: Okay and I certainly didn't mean to imply that that was, you know, that PCPI should've been testing this on multiple EHR's and I get that. I'm curious what the answer there is. It's sort of a bigger question.

Heidi Bossley: Yes and it's one that NQF is trying to answer and looking to people such as PCPI who are working on this as well as others who are implementing. I don't think anyone knows the right answer to it.

Male: Okay.

Male: Other members of the sub-committee who want to chime in on this measure and the discussion we've been having.

Eva Powell: This is Eva and I will just chime in kind of as someone who served a lot of time on the discussion in HIT Policy Committee and the various workgroups including the quality measurement workgroup.

And it occurs to me that what we're doing here today is to some degree a chicken and egg kind of activity because as we've just discussed there is no answer yet to the question of who is responsible for ensuring the reliability and validity of the actual tool for collecting this, not necessarily the measure? And I think those are two different things as we pointed out, but those are important.

It's so much so that that has been a significant amount of testimony particularly on the part of the American Hospital Association that the quality metrics generated by most EHR's these days are not worthy of use period because they're not reliable and they're not valid. And so that is a bigger issue for - a serious issue not for this group to solve, but it would see to me like part of that solution and where it does impact what we're doing today is that to some degree it's an issue of standardization.

And if we think about what we're doing as endorsing measures with very specific specifications in how they are defined and collected, then the degree to which we do - or whatever we come up with, whatever product we come up with then needs to be used through the other NQF process and product of the 2DS or 2DM I think that they're calling it now to be very clear and specific about measurement and data elements that then can be programmed in an EHR.

So I kind of see this as having lots of fingers into lots of different areas that are well beyond the scope of this discussion, but this discussion could in many ways drive a lot of what happens in those other areas.

And so I don't - I guess my question from all of that is what role should those kinds of issues play in our decision making because it kind of pursuant to our previous discussion, my assumption was that validity would not be a huge issue because we are talking about an automated process that would need to be validated at some point that for the measure itself validity would be out nearly 100% if you're assuming a reliable product being the EHR.

But the bigger issue is making sure that we define things specifically enough such that technical people can program and produce standard such that these products can be developed and be valid and reliable if that makes any sense. I apologize ((inaudible)).

Don Casey: No, I think your points are well taken and, you know, I think staff is trying to capture a lot of the nuance that you talked about and Robert alluded to. I want to be mindful of our time and I just want to clarify with Lauralei and (Karen), we're not asking for any specific additional decision making with our committee members.

We're just asking for further dialogue about what we see to date about your initial impressions and the feedback that we've gotten so far from the MA PCPI staff. So am I right?

Eva Powell: That is correct, although I will add that if after a discussion anybody want to go back and revise any of their evaluations, they can go in and do that. So basically just fill out the tool again for that particular measure.

Don Casey: So, so let me ask a question of the group. Does anyone feel the need to go back and do that based upon discussion? Who on the call, on the committee feels that they want to change their mind about something?

Dana Alexander: Change our -- this is Dana Alexander -- change our mind about...

Don Casey: About any of the initial ratings that you've done on this measure. We have some summary data on your initial impressions.

Dana Alexander: Yes, be based upon in terms of applicability to electronic EHR's or?

Don Casey: Well, I think in terms of the NQF criteria that you used to judge these. If you want to - I'm just trying to get a sense of how disparate the discussion had led us in terms of changing anyone's mind about the initial impressions of the measure evaluation.

Dana Alexander: Okay, so before I answer that, let me say that I was approaching this that the NQF criteria that this does not necessarily these measures to meet specs as before the quality data model, but that would be great if that's how if we were, you know, to the point. But the fact is we're still living in, you know, paper and electronic world and not everybody is ready for, you know, E measures.

Don Casey: Right.

Russell Leftwich: This is Russell, I agree and look at it the same way that the question about electronic record was a comment question and not does this determine whether the measure's acceptable or not.

James Lee: This is James Lee; I think one of the feedback we received about this measure is maybe a little more information about successes in sub-populations because the endorsement that we are making is a fairly broad denominator that includes many settings. And to the degree that we have more confidence from a literature standpoint, I suggest that this is applicable in many settings upon discharge.

The more I think we're comfortable with moving forward with this measure.

Male: So James, you would hope for some additional enhancements to the evidence that was already provided?

James Lee: Right, sufficient evidence that this is applicable in variety of clinical environments.

Male: On a variety of populations.

James Lee: Yes.

Male: So that's good feedback for the PCPI staff. Any other before we move on? I think the EHR comment is well spelled out in terms of what some of the questions are that remain and I think James' point is a very good one. Is there anything else that's burning on this measure so we can move forward?

Eva Powell: Sorry this is Eva and I'll try to be brief. I agree with James and I think that's part of what I came at all these measures with, but particularly for this one and any others that were very much - well, that are so salient to where we are right now especially with EHR's and quality measurement is that so much of what's hindering the quality measurement is the lack of technical capacity to collect data across settings.

And so I kind of do endorse the measure as one lever for creating the demand in the market for products that can actually do that. And so that weight on my mind in terms of the importance of the measure is there is no way to get at what James is talking about. How are we going to ever develop the evidence? And I guess that's the nature of the chicken and the egg that we talked about before.

But that definitely colored my evaluation of these measures in terms of the lever that endorsed quality metrics are to creating some of the capacity that we're lacking.

Don Casey: Right and remember even in that, you know, one of the intents of the NQF endorsed measure processes is that these would then move back into the realm of what we call accountability for both public reporting and payment as two examples.

Eva Powell: Right, right.

Don Casey: So I think being intentional about this is good. It looks like from what staff has put together there's kind of an even split on many sides of the question with the ultimate sort of feeling being a bit balanced towards the S side. But this is a sub-group that is really starting the process of bringing this forward to our larger group which we will - we use this feedback as we go forward.

So this will not be the last time we'll have a chance to discuss your vote on this. This is really the first step at it.

(Kendra Hanley): Dr. Casey, this is (Kendra Hanley) from the PCPI. I'm wondering if I can just make one comment related to some of the questions related to the EHR acceptance.

Don Casey: Please and if you have any follow-up, by any means giving us any follow-up information would be welcome, but just briefly let us know.

(Kendra Hanley): Sure, so we are very aware of the initiative around the HIT standard committee and the clinical quality workgroups, etc. These - actually all four of these care transition measures developed by the PCPI are a little bit different in that we're asking for specific patient information and so it's actually not possible from our end to detail every possible diagnosis that would be required to meet the measure.

And so as an alternative to sort of how we usually identify the data elements and build a value set, we've provided guidance in our specification section about how an individual facility could use the available standards to query the information and to build reports within their system.

Don Casey: That's right.

(Kendra Hanley): So I would offer that as well.

Don Casey: Thank you and I think James' point was that diagnoses were important, but sub-populations are what he's been driving. So I think we need to be sure to distinguish those. I'm going to move us on because I think we've talked a lot about this and I think in this process we're probably going to get a little more streamlined in our next discussions because it sounds like some of the topics are going to carry forward.

But if we could bring up the next measure which would be by my mind Russell discussing 0647 which is transition record.

Russell Leftwich: Yes, right. And mindful of the time, I'm going to...

Don Casey: Can we move it up on the screen please?

Russell Leftwich: Mindful of the time and knowing that there's a lot of overlap between 647, 648 and 649, I'm going to suggest that I run through this and then we run through the other two before we have a lot of discussion with that.

Don Casey: Good idea.

Male: Good idea.

Don Casey: If Eva and (Denise) are comfortable?

Female: ((inaudible)).

Don Casey: Okay, good. Go ahead.

Russell Leftwich: And I know that there's a lot of overlap in the references that are cited as well. So 647 is Transition Record with Specified Elements Received by Discharged Patients and the specified elements are spelled out in our key elements of a discharge summary I would say.

The percentage of patients regardless of age discharged from an inpatient facility to home or any other site of care which I believe is any site of care -- my interpretation -- and there were some comments about the ambiguity in what an inpatient facility whether that's a hospital or any inpatient facility. So I'm not sure whether that's related to the way the form is filled out or there is actually a discrepancy that needs to be resolved.

And the only exclusions are patients who died or left against medical advice. The denominator is all patients regardless of age and I would say a brief comment, the evidence seems to be mostly about adults and older patients, not so much about all ages.

And the evidence cited, my observation is that it's sort of one off from the actual measure itself and deals with the importance of information at discharge summaries, not necessarily information transmitted to the patients. The evidence in my reading through it is about delivery of the information to the next setting of care, particularly primary care and not to the patient themselves.

Nevertheless, the importance of this measure was unanimously considered high. I put it in a category of a severed femoral artery should be we stop the bleeding. And there was sort of a split between high and medium and I'm not sure that's significant on the scientific acceptability and the validity that the usability was generally considered to be high.

The feasibility for reasons I'm not sure about are - was tended towards the moderate rather than high assessment. When the measure is really delivering this summary information to the patient at the time of discharge, I find that the feasibility of collecting that to me shouldn't be difficult. And but there was - of the four people who made a preliminary assessment was unanimously considered to be meeting the criteria for endorsement.

Don Casey: Can you comment Russell on the - it sounds like some of the discussion we just had from 46 - 646 around inter-rater reliability also comes into play here. Is that fair?

Russell Leftwich: Yes.

Don Casey: And this notion of contrasting the electronic versus the non-electronic environment in terms of some of these measures.

Russell Leftwich: Right and my personal bias is that that's a problem, but it doesn't necessarily speak to the endorsement of the measure.

Don Casey: Right.

Russell Leftwich: And the word that wasn't used in the previous discussion that I think should be highlighted as well and in my day job dealing with meaningful use that certainly comes up is usability. You know, the systems have the functionality, but the amount of manipulation and work

around an electronic system that are required to get the measures out or reporting out is substantial in a lot of cases.

Don Casey: Can you remind us what the specified elements are? I think that might be useful just to recount in a summary format.

Russell Leftwich: Sure, so the - under inpatient care the reason for admission and the discharge diagnosis and the measure procedures and tests during the admission which really speaks to a few care admissions I think and opposed to discharge patient self-management medication lists related directly to the last measure and the study's pending at the time of discharge and that the patient instructions which is of course a very broad category.

And then the advanced care plan which directly connects with one of the other measures we have in our consideration. And then contact information for immediate follow-up and planned and scheduled follow-up care including a designated primary care doctor. And it's implied that that should be 24/7 contact information, but not necessarily what the mechanism is, so.

Don Casey: So other questions or comments? That was a great summary Russell. Other questions or comments from the steering committee group on this?

Robert Palmer: This is Bob Palmer, may I apologize once again that I have to leave. But I wanted to just address a couple things before I go. First is that the intent of this is that it applies to any inpatient facility, so that would be hospital, long-term acute care, hospital, skilled nursing facility, nursing home. It would not apply to patients who are at home or living in assisted living or apartment.

So it would be very broad in its application. Also, it's - the concept was that this is different from a discharge summary, but could be part of a discharge summary since the discharge summary doesn't have to be completed within 30 days of the patient's transfer from a hospital. So this

would be a limited amount of information, those elements that ideally would go with the patient at the time of their transition.

Russell Leftwich: Right.

Don Casey: Robert, I just want to be sure from a technical standpoint that I'm certain of what you just said about the definition of inpatient. Is it staff and AMA's interpretation of inpatient includes things like skilled nursing facilities, etc.? Because when I see inpatient I think hospital or post-acute.

Russell Leftwich: Yes and...

Don Casey: The staff or AMA have...

Robert Palmer: That's why the word inpatient facility was used, to be as broad as I outlined.

Male: This is ((inaudible)). As I remarked in going through things, the elements that are listed really suggest an acute care admission and not other inpatient facilities.

Don Casey: Right, so can I just ask the PCPI staff to help clarify this for us? Is inpatient defined broadly or is it in hospital?

Female: It's defined broadly so any inpatient facility as Dr. Palmer mentioned including nursing, etc.

Don Casey: Okay because I wouldn't think skilled nursing facility is - or a long-term care facility is consistently called an inpatient facility. So we may want to just change that title or modify it a little bit just to be sure that we reduce confusion because in my experience -- I understand what you're

saying about the intent and I agree with it -- I think that this title could be confusing to quite a few from the NQF's staff's perspective so if we can sort of resolve that I think it would be helpful.

Male: I would have to say that the evidence - that the references cited certainly are all about acute care studies that are around acute care facilities.

Don Casey: I think that's a question quite frankly that we need to sort of think about because again I agree with the intent, but I think we have to be careful about the term inpatient facility because I think it does have some explicit meaning in certain circles. So let's just be careful about it, that's all.

Male: Right.

Don Casey: Other questions or comments from the sub-committee?

Dana Alexander: Yes, this is Dana Alexander, a comment for this measure, but actually for all the measures that we were looking at. In terms of again terminology using primary care physician and I've seen some places with primary care - primary physician or other health care professional, but particularly in like these specific elements to make sure that we're using that type of language versus just limiting to primary physician.

Don Casey: So Dana, I think your point is addressing the question of who is the accountable agent and/or accountable group that would be responsible for this and would be the unit of measurement. And so I think that's good feedback because I think that sometimes these terms again get used kind of interchangeably and may create some confusion in interpretation.

So any effort on the part of the PCPI staff and NQF to help us clarify that would be helpful.

James Lee: This is James Lee; I have a great comment about these measures overall and perhaps a sub-population invisible and I would like to request the PCPI consortium to perhaps give us some guidance. You know, since the population is not stated, but present, are the patients that are dual eligible or have special needs? And these folks are high utilizers as demonstrated by measured data.

They're often living in a supervised living situation such as distance living. Transition into those facilities is important and often there's discontinuity because the living situation changes. And so that, you know, for transition to be successful and in follow-up, often there's only information about where they end up.

I don't know if there's any literature today that addresses this particular issue or how to incorporate some element of consistency around this special needs population of assisted living. Just food for thought.

Don Casey: So James, it's a good point. I think we should make note of it. I think it underscores the fact that as Russell aptly pointed out, we're sort of dealing with the basic training approach to this to be sure that every patient gets at the very least this and underscore the fact that this is necessary, but not sufficient especially for more complex populations such as the one that you mentioned.

And I think that probably ought to be underscored in our thinking so that this doesn't then turn into okay we're done, rather this is the beginning of really looking more closely at what we're trying to accomplish for a given patient.

James Lee: Thank you.

Eva Powell: Yes and this is Eva, just to add to that comment. It brings up just the whole issue of disparities as well and whether or not these are potential measures to simply be stratified by whatever disparity you want to look at or if they themselves given some of what James just said could be considered indicators of disparity.

In other words if you have poor coordinated care, is that an indicator of - is that more prevalent in populations that are underserved? But that might be future work for PCPI.

Don Casey: Well, so Eva, I think the point is well-taken and I think that often times what we see in disparities research is that common activities that we think should be obvious for everyone doesn't get to certain particular groups and so it's back to the notion that this would help us at the basic level to help quantify whether there were disparities in terms of how this type of information is collected and transmitted knowing that James' issue is the more important, you know, sort of topic here to figure out for these special populations.

But at least then we'd be looking to be sure that the special populations were achieving the same consistency as other populations on these basic measures.

Eva Powell: Right.

Don Casey: So I think that's a good comment for PCPI.

Male: Along those lines and I wondered in reviewing these, is there any limitation on the categories of disparities that are to be considered?

Don Casey: Well, I think that from the standpoint of this measure let me suggest that that's going to end up being kind of a different - a related, but different discussion than this measure. So why don't we leave it that the group has a question about this, but I don't think as I read this measure that

there's an intent to develop more technical specifications around dealing with the disparities issue at this point in time.

This is really again saying every patient that we take care of ought to have this transaction as I'll call it occurring at the point between moving from Point A to Point B in the whole system.

Mark Antman: Don, this is Mark Antman for the PCPI. May I just offer a comment on that?

Don Casey: Yes Mark, please.

Mark Antman: Thank you. We do include language in the submission forms for all of our measures; certainly it was in for all of these care transitions measures that states that we encourage the results of the measure to be stratified by race, ethnicity, gender and primary language. And we include those variables as recommended data elements to be collected.

So that's an instruction that we provide for all these measures.

Don Casey: So that then there would be data elements to do the analysis that the group has been talking about Mark. I think that the other feedback is we want to be sure that the next step of care transition communication for some special populations goes well beyond the intent of this measure and that this is kind of a for all type measure.

So I think that's the duality of the input here that I think is important, so.

Mark Antman: Right, we understand. Thank you.

Don Casey: Other comments or questions from the sub-committee?

Male: I got a question on these measures where you say these don't lend themselves to traditional EHR specs. I'm just curious why not? I would think it's, you know, you have a very firm idea of what needs to be in these records, why not lay it out to see?

Don Casey: Russell, do you want to - do you have an insight or do you need the PC - the AMA staff to help us with that?

Russell Leftwich: I would appreciate some help.

Female: Be happy to help.

Don Casey: In the interest of time let's be brief because I know we talked a lot about this previously. Let's try to capitalize it and then we can do follow-up on it. We still have four other measures we got to get through.

Russell Leftwich: I think two of them are sort of the same as this one in many ones. I think this will apply to all of them.

Don Casey: Right.

Male: If there's dozens of EHR companies or dozens, you would think you'd want to be very standard about exactly what elements you expect to see for this account. So I'm just curious, I know you have some rationale for not doing those, but I don't understand it.

Dana Alexander: So the reason we can specify the type of information that we require and we can provide guidance as to how that should be queried and reported. However, if we were to try to detail a global list or that could be applied to any patient in the hospital, that list of, you know,

tests they received while in the hospital, procedures, tests remaining post-discharge, etc., that would be infinite.

Male: Right Dana, so how do you know? I mean, other than I know it when I see it, how do you know that it's going to be up to snuff?

Dana Alexander: So meaning how do we know if it's actually includes everything, is that correct?

Male: That it should, right. I mean, how do you know you look at this and you say an EHR generated transitional record is given? How do we know it's actually good or appropriate or useful?

Don Casey: So I would suggest in the interest of time, you've asked a key question that I don't think we're going to be able to spend a lot more time getting to. I think it is a challenge and I do think that it is at the center of issues like reliability and validity. So I would - it sounds like this is going to be a theme through a lot.

Male: Okay, no I mean I don't want to - I'm positive on these measures they're critical, I just think these are difficult issues that we're going to have to sort out.

Don Casey: Right and I think that the question is that this is obviously a work in progress and in the meantime while we're trying to achieve nirvana through the perfect alignment of the stars of the electronic health record, information vendors, group hug, we hope that in the meantime we'll give people some tools and resources and insight about how to do this on a day to day basis so that we don't let patients fall through the crack in the meantime.

And I think that's the challenge of these measures which are kind of sitting between the - as someone said before the chicken and the egg about, you know, our challenge right now where we are in terms of the technology.

Russell, do you want to - or is there anything else in the evaluation results from participants that you want to highlight? It looks like to me there was high to medium belief on these. It looked like we only got about four people voting at the end informally.

Russell Leftwich: Right, right.

Don Casey: But most people ended up on the positive side of believing that this was an important measure to move forward to endorsement.

Russell Leftwich: Yes, yes.

Don Casey: Does anyone who didn't have a change to weigh in on the final - do you want to add anything or if not I will just move on. Does anyone who didn't get a change to review or comment it want to add anything else?

I just think - I think the discussion on these past two measures has been very critically important and I think these are going to be important generic issues for us Lauralei to address with our committee because I think they're going to come up time and time again.

So I have Eva on 648.

Eva Powell: Yes.

Don Casey: Eva, do you want to sort of without overdoing too much of what we've already discussed kind of move us through this one?

Eva Powell: Sure, I'll be very brief. The distinction between this measure and the previous one seems to be that the previous measure focused on providing information to the patient in the context of a transition. This measure focuses on providing information to the receiving provider. So it would be kind of a closing the loop type of measure.

Looking at the summary of the results, it seems very similar to the previous measure in that usually that's a high - that the impact is pretty - considered high and that the evidence is somewhere between high and medium. And the evidence is the same as for the previous measure. I'm not going to go through all of that again.

Don Casey: This is the Russell let's stop the bleeding comment, right?

Eva Powell: Right, exactly.

Don Casey: We're going to carry that forward Russell.

Eva Powell: Let's provide information to the provider who is tasked with caring for a patient. So I guess I'll just leave it at that for the sake of discussion. We've covered a lot of that. I will say kind of relative to the comment before and coming at this from the perspective of someone whose been on almost every single policy committee and policy committee workgroup and policy committee workgroup/sub-group meeting, that the issue of, you know, how you know if this is good enough?

How do you know if the right information was provided? What we seem to be struggling with is whether that's a policy issue or a practice issue? And it becomes a policy when tax payer dollars are going to someone based on whether the answer is yes or no, but that is increasingly difficult for all the reasons we've mentioned.

So I think these measures while we're unlikely to have them be perfect at the end, I think that they're critical to give us information that we really need moving forward both from a policy and a practice perspective.

Don Casey: So public reporting and quality improvement, it looks like the group generally felt that both were in play here for this measure?

Eva Powell: Absolutely.

Don Casey: Yes, let me just go back to the topic again. I'm a pet peeve about this Eva, but I want to be sure that the title, the way it's worded at least on the last form, I've got which says transmitted to facility. As I heard it or heard you say it, it sounded like that was the intent of the measure which is that could be a physician office or a clinic or somewhere else and I'm just cautious to the NQF staff and the AMA PCPI staff to be sure that we're not creating confusion by the terminology.

And that if facility is the terminology that perhaps many might interpret that as another hospital. So I'm just trying to be cautious about being sure that our title is a little more reflective of the more generic focus here and that we don't get boxed into a corner with the title only because these things get listed out in let's say proposed rules where it's just the title of the measure, it's not the specifications.

So I'm just being cautious about saying that that title could maybe be cleaned up a little bit. And that's a minor editorial probably. But in the meantime I think does anyone else have any comments on what Eva's presented on this measure that's independent from what we've talked about before with some of the technical issues?

This seems to be sort of a transactional measure Eva, that is Point A and Point B have a handshake.

Eva Powell: Right, exactly.

Don Casey: And that we verify on both sides that - and I didn't drill into the details of this that people on both sides of the handshake understand what the handshake is about and the details of the handshake. And I would assume that that is addressed in this measure, not just the fax arrived at 12:22.

Eva Powell: Right, right. Yes and let me go through because one thing that I actually am wondering about in the course of our discussion is just having been part of a number of conversations, there's been a lot made of the fact that these kinds of transactions involved both the sending and the receipt and kind of your point that, you know, more than just what the fax sent. And I'm just looking to make sure that that is reflected here.

To save time, is anyone - is the measure developer able to answer that question?

Don Casey: PCPI? Matt or Mark, do you have any insights?

Mark Antman: Right, this is Mark Antman and that's AMA PCPI. So with regards to what you said earlier about assuming that the measure addresses as I think you said the handshake implied understanding at both ends. Frankly this measure is not quite that ambitious.

The intent of this measure was to confirm that the information did arrive at the next provider of care whether that an inpatient facility or the primary care physician or some other physician caring for the patient, but it does not go so far as to attempt to confirm any action on the part of the receiving facility or physician.

Don Casey: So the combination mark would be if we put 45, 47 and 48 as I'll call them together, it would be we want to be sure the meds are reconciled. We want to be sure that there are specific data elements documented and then transmitted and then we want to have a record that the information that we did in the first two measures actually is received by the end user.

And so you're looking at that sort of as kind of parts of one piece?

Mark Antman: That's absolutely right Don and for that reason that we proposed those three measures as what we refer to as a bundle of measures.

Don Casey: Yes.

Mark Antman: Meaning that if you do one, you should do the other two as well.

Don Casey: That's right.

Eva Powell: But the focus is actually on the receiving rather the sending. Not necessarily action taken because of the received, but is that correct?

Mark Antman: So the focus is actually on the sending rather than the receiving.

Don Casey: So the measure target would be the transmitting, in this case a hospital?

Mark Antman: I'm sorry Don, when you say the measure target meaning?

Don Casey: Measuring the transmitter, as you said the hospital in this case.

Mark Antman: Yes, that's correct.

Don Casey: Saving a record to the physician office let's say.

Mark Antman: Correct, we are measuring the transmitter.

Don Casey: And for those ((inaudible)), again I apologize for this. Those organizations that do have actual intraoperative EHR's between inpatient and outpatient, I assume that the presence of this through the EHR which would then be automatically available in other settings, would the facility attend to the measure easily? I mean, I think that's a dub, but I just want to be sure that's considered success too.

Mark Antman: Don, I'm sorry, was that a question to PCPI?

Don Casey: Yes, yes.

Mark Antman: So we anticipate that yes EHR's will provide that capability. I think when the measure was being developed, it was felt at that time that it was too ambitious to require as a data element needed to meet the measure confirmation from the receiving end. And so the measure was limited to confirmation that was in fact transmitted.

But the confirmation of receipt or any further action at the receiving end was not actually included in the measure.

Don Casey: Right, if it's done electronically that would meet the intent of the measure I think is what I was asking.

Mark Antman: That's correct.

Russell Leftwich: This is Russ, as a footnote, in the electronic world if there's an electronic transmission there is an electronic acknowledgement that it was received that might not normally be displayed, but could be in the electronic document world of HL7 CCD type documents. There are data elements that are specified or can be specified as they must be present or else the receiving system will not accept that document.

Don Casey: Right, so let's just add that in to sort of, you know, kind of our checklist on the electronic health record side of these measures which I think Mark sort of pointed to, but I think Russ you're saying there are some technical issues here that would need to be clarified and worked out in order to help the end users.

Russell Leftwich: Yes, but could enable that element of receipt being confirmed.

Don Casey: And could enable it, so good.

Eva Powell: Well, and I think that's exactly right, but I would phrase it as - and I think that is a really important point for the work that we're about in all three groups is to note where there are specific pieces of information or data elements that would need to automatically generated by the electronic system because that's something that needs to be specified, standardized and programmed.

And from everything we've ever heard in a policy committee, the technology is not an issue. It's all about what is incentivized and what the vendors are incentivized to produce and if we - the federal government says we are requiring you to collect this measure and these are the specifications and you need to give us proof that this was received, then the providers are not going to have a hand tally of that, that the vendors will produce that.

Don Casey: Right.

Eva Powell: But I think it's really important to call those things out because it doesn't happen automatically. I think that's an important - something that we can contribute from this group.

Don Casey: Absolutely and I think these are going to be really good sort of summary comments the NQF staff will put together for us. Any other questions on 48 before we move to 49?

Male: Yes, I have one. So for the folks for the non-EHR transactions, is there any data to suggest that just sending, like is there a rate of acknowledgement of the receiving practices or facilities? Particularly practices so that to leave it just as monitoring that it was sent if there's data, if there's any evidence of only a fraction of those have been acknowledged or acted upon that might be an insufficient standard I think.

Don Casey: So your question I think is should there be a paired measure which alternatively the receiving side of this uses to validate if that's the right word or to measure the receipt of this information.

Male: Right.

Don Casey: It's a good question; I could see some confusion in the sense that some of the receiving entities may not even have a clue that that's something ought to be sent to them. So but I think it is fair game for Mark and the PCPI staff to consider in terms of this. I understand we're getting into a little bit different measurement domain here and a little bit different issue, but it is connected Mark and I think it would be useful to sort of maybe have some thinking about this.

I'm not aware that there is another measure that does this at this point.

Mark Antman: Don, this is Mark again. So it's entirely possible that there is one from another measure developer, but there isn't another PCPI measure that addresses that. But I would...

Don Casey: So one thing we ought to do is just maybe a step to double check that to see if in fact there is something in existence because I do think that is an important point. But I'm sorry Mark, go ahead.

Mark Antman: Thank you. I just wanted to add that the evidence that we have cited for this measure and for the other measures in fact primarily relates to what is known as the - what we know to be the impact of the lack of the information when it was provided. So where as it doesn't pertain directly to the benefits or the results of the receipts of the information where the action's taken on the information, there is a lot of evidence related to what are the consequences of that information being absent?

Don Casey: Yes, good point. Very good. Any other comments? Eva, do you have any final closing thoughts on this one?

Eva Powell: I don't think so; I think we've had good discussion.

Don Casey: Okay.

Eva Powell: So it seems that people are in favor of it remaining endorsed.

Don Casey: Yes. Okay, let's move to 649. I have (Denise) on this one and (Denise) again, comment in the context of our other previous discussions.

Female: (Denise), are you on the line? We're not sure that (Denise) ever actually called.

Don Casey: Oh, maybe (Denise) didn't make it. Let me ask you if anyone else who commented on this and voted on it wants to say something? This is one that is discharged from the ED, right? So this is a different domain than the last one?

Dana Alexander: Well, this is Dana Alexander. One comment that I have that's related to the elements that I just was sitting here reviewing this realized is that we talk about again, you know, requiring what was done to the patient procedures and tests. You know, what's the plan for follow-up care. You know, medication. But there isn't any kind of requirement that I see stated here in terms of, you know, how was the patient received.

Any unexpected events that occurred while the patient was in the ED that might be important information for caregivers in the ambulatory care setting or home care setting to understand.

Don Casey: Could you give us a little - yes give us an example.

Dana Alexander: Sure, let's use an example of maybe the patient is diabetic and, you know, were they coherent? I mean, again what kind of, you know, orientation state did they arrive in the emergency department? So that might be, you know, useful information.

Don Casey: It might be hard to - I guess you're making sort of room for other comments, is that kind of, you know, what you're after is kind of, you know, any other information that might be deemed to be useful?

Dana Alexander: Exactly.

Russell Leftwich: So I had observed on this one that although it says specified elements in the title of this, that's not in the brief description of the major nor any specified elements that were listed as they were with 47.

Don Casey: Do you agree Dana?

Dana Alexander: I have to go back and review the detail on that in order to comment.

Don Casey: Anyone else, Russell's observation is a good one? Anyone else sort of saw that here?

Russell Leftwich: I think I entered that in my comments, but I did note that as I look through it.

Don Casey: Yes.

Russell Leftwich: My other observation was the references cited for this measure really have to do with inpatient hospitalization and not emergency department encounters.

James Lee: This is James Lee; I think that from a fairly high level of looking at this particular measure, it's a good measure in terms of providing clinical delivery to our patients. Taking this to another level, in some of the communities ER has played a central role in creating care plan for example pain management and that through a real and other elements of infrastructure in electronic health record so the entire community knows about the care plan for the patient with particular pay me.

And that's been very useful in terms of reducing ER visits. In this case of transmitting to the patient with a clear care plan I see as a component as an overall plan that has some clinical application, you know, broader level for community. So it's a good measure.

Don Casey: Do you agree with Russell's observation James though that the detailed elements of this weren't as well-specified in the measure description that was sent out? Do you have that insight or do you remember?

James Lee: Yes and I do agree. I think that what we're talking about maybe is harmonization of what those elements ought to be in transition of care.

Don Casey: Yes, yes. Exactly.

James Lee: And I know (Colman) has done some work and has physician papers around this, so.

Don Casey: So let me go back to Mark and his team. Mark, did what Russell say hold water with you? In other words, do you see on your side a little more detail about the specifications of the components of the information that should be - it should be included in this transition record?

Mark Antman: Yes, the comments are very understandable given that we very clearly were less specific for the requirements - or less stringent as you will as to the requirements in the ED setting, but that was very deliberate in that we worked closely with emergency physicians in developing the data elements or rather the numerator elements for the measure that is being discussed right now.

And the intent was in fact to try and capture all of the details that were described in the previous measure, the measure for all inpatient discharges, but describe them in such a way that was realistic in the ED setting understanding that given the various differences of the ED setting and the timeframe of the discharge as it takes place from the ED, we very deliberately scaled back a bit if you will on the description of the elements that were essential for the transition record in that setting.

Don Casey: So James, I think the message from Mark is that the ED physicians for whom this would likely be the unit of their measurement wanted to be sure that in the context of their work flow that they would agree that they're on the hook to do this, but also preps may be allowed to get more basic with their intent in terms of what's being transmitted to the patient at the next point.

And I think Mark the feedback for you as James says that there is evidence in the world of emergency medicine where getting more specific can actually help improve patient outcomes. And so I think we're going to be left with just the way it is and I think James if you're comfortable, you know, we should reflect your good insight about what you said because I totally agree with it.

And I think others would too. And be sensitive to what Mark said about the fact that emergency docs - in other words, the care people who focused in on this measure recognized that this was a big deal and wanted to be in the game so to speak in the beginning knowing that there's still a lot of work to do with many of these other issues that you're describing.

James Lee: I applaud PCPI's in listening to emergency room physicians is the right way to go.

Don Casey: Well, these mostly come through the specialty societies that are relevant to the, you know, to the measure domain so you can be sure that it wouldn't be here without their input. But I want to ask if anyone else has any other thoughts about this? My suspicions are Mark that the same discussion we've had about the electronic health record to some extent apply here as well.

And it sounded like those are becoming generic and so we'll add this one to the list as well. Are there any other - any questions or comments about 649?

It looks like there was for the most part a pretty good balance on the side of moving this forward for endorsement with the group knowing that there were some concerns. You know, Russell expressed some; James expressed some moving forward with sort of advancing this to its effectiveness as a performance measure.

Russell Leftwich: Yes, this is Russell. I think if there are some published studies that relate to the emergency department discharges and patient instructions - information provided, that would be

good to capture those because the ones listed really are about including by (Eric Coleman) are about inpatient hospitalization, not emergency department.

Don Casey: Yes, so that would be maybe James if you've got a line in this and Mark your staff if there are ways to track those things down I think they would enhance the evidence behind the measures. So we'll leave it to you to sort of do a little digging. Not a lot, but a little to see if you can address Russell's point about the evidence to date being on (Eric's) side which is still is available, but can be enhanced.

Male: Yes, I know it's not a great leap of faith to think that patient instructions leaving the inpatient setting are unrelated at all, but if there are studies that would be helpful particularly if they had other data elements that turned out to be important.

Mark Antman: This is Mark at the AMA, this is very helpful feedback for us to hear and we certainly will do some additional digging. So thank you.

Don Casey: And James may have a line of some things too which I'm sure he's already thinking about, so.

James Lee: I'll certainly look into it and share it with you.

Don Casey: Great, someone is buzzing and I'm not sure what that is, but maybe the staff could ask the operator to get that to stop if we could.

Operator: I ((inaudible)) that line.

Don Casey: Then in the meantime let's talk about 520, 0520. Dana, I had you on tap for this one. This is the drug education on all meds provided to patients/caregiver in the title, it's a CMS measure.

Dana Alexander: Yes.

Don Casey: And I don't know if our CMS colleagues are on the line. Let me just say before I do that, that the AMA PCPI staff we thank them a lot for being on the call. It is not necessary, but I think Lauralei it's certainly acceptable for them to remain on as public commentaries on the other measures. So we'll invite you to stay tuned on this call while we finish up here.

But Dana I want to give you the floor now.

Dana Alexander: Thank you and unfortunately I have to leave in about five minutes to catch a plane, but let me introduce this and I will leave to others to go through the discussion. Again, as related to this measure there was much overall agreement it's a high impact measure and agreement by the majority that the criteria have been met.

As related to the reliability and the validity, there was strong agreement as related to reliability that people felt the reliability was high. As related to validity, there was mixed review and responses. And I think to explain that is that there was a feeling that the validity did not necessarily show the connection between the measure and the outcome while the topic of patient education is felt to be very important.

That again, just giving education, checking out the box that education was done does not necessarily, you know, validate that the patient actually, you know, consumed and absorbed the actual education content that was given to them. And that my thought on this was again how then can we demonstrate and if there will be a requirement that you sort of demonstrate repeat feedback from the patient as to their level of understanding?

And have them repeat back the, you know, what are the potential adverse effects? And, you know, when they should report a problem? And how do they really monitor effectiveness of the drug therapy? And so to hear that back from the patient that they understand truly the education that was given to them. So that is my comment as related I think to again the validity of this.

And I think I'll stop right there and turn this over to the rest of the group.

Don Casey: Are there any - before you run out Dana, are there any questions for what Dan - or comments on what Dana said? And then we'll let her get her plane.

Male: So I had some issues with the validity here and actually more on the next measure than the last one we discussed, but I am not familiar with what OASIS is so that may be part of the problem.

Don Casey: OASIS is the documentation system that is used by all home care agencies; it's a standard data set similar to the minimum data set used by long-term care. And you can look it up online, but I do think embedded in that is an expectation, for example that patients receive education about a variety of things. And so OASIS is pretty standardized in the home care industry and is a requirement for payment, so.

Male: Okay, so I mean I guess what I want to see I think -- correct me if I'm wrong -- for validity is the assurance that checking off that code means that it was done. That someone should look at a record and say yes if it was done and then the code's checked off. And if the code's checked off, then it was done. Is that right? I mean, my question is what validity would be, that yes meaning this measure, meaning that coded check implies that this was actually done?

Don Casey: I think that's - Dana, are you still here?

Dana Alexander: Yes, I am still here.

Don Casey: Is that - that is the intent, right?

Male: I think OASIS is, you know, I've never used it. It sounds like that would, you know, it may pass that test, but that's something what I was looking for.

Don Casey: Yes, we did education, right?

Dana Alexander: Right, right. OASIS you're right, it does have a checkbox as related to education given to the patient. You know, but again - I mean, any of those caregivers can give education to a patient, but did they really understand what we were saying to them?

Don Casey: Right.

Male: Right.

Russell Leftwich: This is Russ...

Don Casey: In the interest of time, I'm going to hold - hold on just a minute. Dana, have a safe trip.

Dana Alexander: Thank you so very much.

Don Casey: Okay and we'll follow up to be sure we capture any information on this discussion, but thank you for that. Other comments? Russell, I think you were...

Russell Leftwich: Yes, this is not really my realm, but my understanding would be that this is the only documentation that there is because in most cases there's certainly no electronic record and I

don't know to what extent there might be other documentation required. But this may be the only documentation if something was done is my understanding.

Male: No, so there's no like actual charts that home care folks use.

Elizabeth Madigan: Hi, this is...

Female: Hi.

Elizabeth Madigan: ...Liz Madigan, I'm with the...

Female: Go ahead Liz, please.

Elizabeth Madigan: I'm one of the developers. I'm also a former home care nurse and I'm agency administrated. They actually do have - these are paper or electronic records that indicate drug education was provided. So OASIS is one element, but there's also additional documentation in either a paper or electronic chart that indicates what patients were instructed on and the patients, you know, family responses.

So they do have that additional documentation. The other piece to keep in mind is that because there are state surveys, what happens is that the state surveyors go in just like they do in nursing homes and other facilities and they actually crosswalk the OASIS with the paper record and they actually also observe home visits.

So if a clinician says drug education was provided, it should also indicate in the either paper or electronic record.

Male: Okay, so that would imply that validity testing for this could be done. I wasn't sure if I saw that it was done.

Female: I think what you're referencing would actually be item reliability testing.

Male: Okay.

Female: And there was some item reliability testing done when the OASIS team was tested. Liz, could you just describe that briefly. I know we didn't include it in a form.

Elizabeth Madigan: Well, what we did is we went into agencies, we went into to 11 agencies and we looked to crosswalk exactly what I said. So I indicated that drug education was provided. We looked in the paper or electronic record to evaluate, you know, was it provided to sort of crosswalk that piece.

Male: Okay, that sounds great. If that was done then I think my concern is certainly met.

Don Casey: Other comments Russell?

Russell Leftwich: Russ again, it did occur to me that there are some dependencies in this that are outside the measure that for example it's dependent on the accuracy of the medication list that is transmitted from the previous setting if you will where you're dependent on that reconciliation. And also there is a uncontrolled variable about how much medication instruction the patient received in another setting.

Elizabeth Madigan: So home care agencies have the same requirement in terms of med reconciliation and they do the best they can. Now you're right, they are constrained by the information they get from the previous setting.

Male: Right and I...

Elizabeth Madigan: They also need to verify with a provided physician because we have physician ordered plan of treatment that includes medication. So I would say they work pretty hard. It's not perfect by any means, but I think they will be ((inaudible)).

Male: Well, I don't doubt that. I'm just saying they don't have the data available to do a reconciliation that say a hospital setting would have. So they're dependent on that previous setting in particular having done an accurate medication reconciliation.

Don Casey: Remind me of who the target is for this measure. Is it home care agencies; is it hospitals and home care agencies? What's the - I just have lost track of it.

Female: Unit of measurement here is the home care agency.

Don Casey: The home care agency, great. So this would be contextualized in the context of what our colleague from - who did the measured development mentioned used to be - was it Liz? What that...?

Elizabeth Madigan: Yes.

Don Casey: Yes it was, thank you. This is embedded in a well-used and standardized instrument that is implemented across all home care settings. So in some ways Russ, this is kind of almost - I don't want to call it exactly an EMR, but it's in essence capturing things electronically that can be documented and includes as Liz pointed out some close the loop documentation that the information was received, understood, processed by the patient and the family.

So I think this is one where I think actually we're ahead of some of the issues that we talked about on the previous four. It looks like some people, you know, weren't certain about how this is used now and what the intent and process for OASIS is.

I would suggest with this clarification, maybe those of you who looked at this thought the lens of something other than home care, maybe we can provide some technical support as far as, you know, what OASIS is how it works. But maybe you could give a second look at it. It looks on the end of it that everyone still came out believing that this was going to be appropriate for continued endorsement.

So I just think maybe Lauralei if we'd help the team along to be sure because I do know that if you don't live in the home care arena very much that this might be a bit nuanced. So maybe just some clarification about that would be helpful to the committee when we address it.

Male: I was also interested in the validity testing on this, it looks like the measure developers compared the results on the measure with a couple of outcomes measures which seems to be going above and beyond what would even be required for validity testing I think.

Don Casey: Right.

Male: And they were not correlated which is sort of interesting that if this measure was met and education was done, there do not appear to be a change in a couple of outcomes related to medication problems.

Russell Leftwich: That was my - that was the intent of my comment is not questioning the measure or the ability to capture it, but rather whether it has an effect on outcome because of those other uncontrolled variables like being dependent on some medication reconciliation that happened upstream.

Male: Right, it's not their fault.

Russell Leftwich: Right.

Don Casey: Yes.

Male: And I guess it would be my point, it seems like to prove validity you don't even have to prove this.

You just want to prove that if in fact someone checks off an OASIS that medication was done and in fact we can trust it was done. That to me would be validity for this project measure.

Don Casey: Right, right.

Male: But what they provided was going well beyond that and it didn't need it, not what the basic validity would be and I just heard someone mention that there were samplings done and sure yes, you know, checking off the box means it was done.

Russell Leftwich: That speaks more to the importance of the measure I think than the validity.

Don Casey: Yes.

Male: Yes, right. That points to the structure process outcome, right?

Russell Leftwich: Right.

Male: It sort of goes back in.

Don Casey: So I think this feedback is useful and Liz, I'm sure you will take that with good will and understand that this is going to be an important thing for us to get a bit more clarity on going forward when we sort of end up voting on the endorsement decision.

Elizabeth Madigan: Sure and ((inaudible)) whose been in contact is also on the call. So between the two of us and we appreciate that.

Don Casey: And they can provide additional, you know, input to these questions when we get into the real big arena where we're going to vote on this. So we'll put that as another to-do. Any other comments on 0520 because I think this is again one that people seem to feel is very important to continue?

The last one Matthew is -- we saved the best for last -- but this advanced care plan is quite interesting and I wondered if you could bring us through this one?

Matt McNabney: Sure, so this measure is as the title implies looking at advanced care planning in the older populations, 65 and older, and a very important topic ensuring that older patients have a form of advanced directive. And we can talk about the range of options that are allowed in the measure being the documentation of an advanced care plan or the -- or, emphasize or -- or the selection of a health care - or excuse me, a surrogate decision maker or the desire not to have.

So there's quite a range of options to be considered having completed this measure. With regards to its importance, people who commented including myself certainly agree that this is an important measure that needs to be - certainly recognized as important by everyone in health care or most in health care that's something that's been difficult to bring into the mainstream as evidenced by the low rates of completing which were cited in the measure information.

The other thing that was important with regard to the measure and its quantity and quality and consistency, there was kind of mid-range support for the evidence with regard to this which there's a lot of interest and a lot of effort, but I think the solidness of how well this was completed and brought into the literature and its impact was reflected in kind of these mid-range scores.

The reliability of it was generally felt to be high with regards to how it was collected. Although the validity -- and I think one of the other panelists commented on this -- you know, the use of CPT coding to represent compliance may not - or to completing this may not represent complete or important or useful completion of an advanced directive by having coded it.

And similarly or conversely, people may not be using the codes and therefore if that's used as the measure of completion, there will be people who may have well done it but not used the codes to indicate they've done it. So there was concern and question about that, so I think...

Male: Can I jump in as the person who have a concern about that?

Matt McNabney: Yes, please.

Male: Yes, you know, I practice - I've been practicing for years, I've never used one of these sort of extra Category 2 codes.

Matt McNabney: Yes, neither have I.

Male: And I'm just concerned that if you use those codes, you're going to come across a lot of docs, a lot of patients, a lot of institutions that are going to say, "God, they're not doing any advanced care plan and they're going to flunk." And, you know, if you look in the records you might see they were done. So I would need to see contesting that says in fact those codes are an accurate reflection of what's in the medical record.

And since I didn't see that, I am concerned that what we're measuring here is use of these codes, not actual documentation of advanced care plans which I do think are important, I'm just concerned how they're measured.

Don Casey: Just to remind us to - Matthew, this is a NCQA measure and I think NCQA's on the phone and we'll ask them to comment in a minute, but it's an NCQA measure and the level of measurement is at the physician and our practice level. Is that correct?

Matt McNabney: Yes. I mean, are you asking me or the NCQA folks?

Don Casey: I'm asking you for your impression of this just so we can validate it.

Matt McNabney: Yes.

Don Casey: And you said yes, so I hear the comments about the reliability of using CPT code in terms of this measure given that NCQA usually implies just a claim space generated code. Sometimes in the early phases of a process where you're attempting to use the administrative data set to improve documentation, this can be the starting point for identifying a gap.

But on the other hand, I know physicians are reluctant to put CPT codes down for things that they know they're not going to receive compensation for. So I think this is kind of a transitional measure as I read the ((inaudible)). I think there's more and more discussion about this being resurrected from the standpoint of payment policy and clearly this got hung up to the Affordable Care Act discussion that, you know, you're paying doctors to be in depth panels and the other.

But I think that sits in with, you know, of what the intent was, was to be sure that physicians when appropriate actually took the time and did advanced care planning with their patients. So I think

this one is sort of suffering from being on that bleeding edge of things as it were to use Russell's hemorrhagic analogy here.

Let me...

Joanne Cuny: This is...

Don Casey: Yes.

Joanne Cuny: This is Joanne Cuny from the AMA and I know NCQA they're probably on the line, but if you wouldn't mind I would just like to clarify here because PCPI assisted with the testing on this measure. We are talking about Measure 326. And the discussion to date has been about the CPT codes and we did do testing in other data modalities that reflect high reliability of this measure.

So I just want to make sure - I mean, maybe you're going to talk about that in a minute. Maybe I'm confused here, but I'm looking at the NQF submission forms and there's also a pretty good testing project that was done at four sites that had both paper and EHR. And inter-rater reliability was done there with very high reliability of this measure. So I just want to make sure that you're seeing that in the measure.

And if I'm just off base, just tell me to be quiet and I will.

Don Casey: No, I think the point was what we're trying to do is - I think the two physicians were talking about this, actually expressed some concern which is that in practice if all that's being used here are claim space codes, then this is going to be a problem. And I think you helped to clarify that you're talking about a combination of both and that this will be most effective when it's done sort of at the chart-based data abstraction level.

Male: I think our concern was just the validity, not the reliability. When I'm looking at the Word document, I'm seeing that validity was assessed with face validity, not with any testing beyond that. I see the reliability testing was done, but the validity testing I see is - I'm not.

Female: Hi, this is the NCQA team who compiled the NQF submission. Could we have - do you want us to respond to these questions just in the interest of time?

Don Casey: Sure, sure.

(Anne): So the first thing that's important to point out is that this measure is in use in PTROF and please let my colleagues at PCPI -- correct me if I'm wrong -- but I believe that this measure is one and a set of measures that practices and physicians can choose to report or not report.

So if a practice is not using the CPT2 code, then one would think that they would choose not to report on this measure which is based off of CPT2 code.

Don Casey: Right.

(Anne): So the rates that you see are not rates looking across all practices, they're rates looking across all practices that shows to report this as one of the measures in their measure set.

Don Casey: So Matthew, does that help to clarify that question?

Matt McNabney: Yes, so would that be - so in the 2A1 to a precise - the numerator details, so is that that second paragraph documentation that patients - so they go in and then - is that what you're talking about (Anne)?

(Anne): So what I'm talking about is that first of all that the testing data that we have is on practices that choose to report on them. So this is not just a random sample of all practices.

Jeffrey Greenberg: Yes, I didn't realize that. That's helpful to me. This is Jeff.

Don Casey: So that I think helps clarify the discordance between the initial understanding and...

(Anne): And I will also say that working on this from an EHR and medical record review, that's kind of in progress. At least that's what I have from my colleagues at PCPI that they're continuing to work on this and that this measure will be strengthened is what we have right now is people using CPT2 code.

Don Casey: And I think this gets back to, you know, the same discussion we were having with the other PCPI measures related to what are the standardized elements of content in the advanced care plan that are addressed? And, you know, I think just trying to be as clear as we can between now and the time we meet to vote on these would be helpful. And I would ask the staff to put this one on the checklist as well.

But I do believe you've added a lot of clarification to some of the technical aspects of how you've evaluated this measure. So Matthew, do you want to - well, let me see if there are other people on the call that have any questions.

James Lee: This is James Lee.

Don Casey: Yes James.

James Lee: I think from a broader health care policy, payment and delivery standpoint, beginning to have a code to quantify this advanced care conversation and answer if we find the elements that goes

into it, you know, codes and content can be standardized on electronic health record. So I see this as a plus and I see this as a way to articulate for the work that doctors do in real life conversations by having good CPT codes and ((inaudible)).

It's a good thing.

Don Casey: Yes, we do know for example that the - in New Jersey at least a physician order for life sustaining treatment which has a lot of attempts to standardize the process of physicians being consistent across settings around the patient's preferences or around advanced care planning is consistent. So I think is very timely and we'll be informed by some of these new efforts that are occurring at state and hopefully national levels as well.

Matthew, do you have any other issues that you want to bring up with this one?

Matt McNabney: No, just to - when I jumped - when I alluded to it at the beginning - so the measure is they having advanced care plan which would imply more of a comprehensive about advanced care decisions or surrogate decision maker documented the medical record. So I'm just - they seem sort of like qualitatively and quantitatively - well, not so much qualitative, but quantitatively different, but either one would meet the standards.

So to say, "Is your wife going to be your decision maker? Yes" is different than a comprehensive advanced care plan discussion. So it seems like you can achieve the measure with, you know, fairly little discussion or with lengthy discussion it seems.

Don Casey: Yes, I think the feedback for NCQA and the -- I guess she just dropped off -- but is to be sure that when we use a phrase like Joanne -- I think Joanne you've been talking about this -- that we are clear on sort of a more standardized definition of what we mean by an advanced care

plan. I think like many other terms like care coordination, this means - can mean a lot of different things to a lot of people.

So being explicit with what are the components of the advanced care plan that we're talking about is going to be important to this in terms of, you know, evaluating the measure at the local site level.

(Anne): This is the NCQA again. I totally agree that this, you know, that this measure has a very broad numerator and it doesn't require a lot to make it into the numerator, however I will point out that performance is still extremely low.

Male: Right.

(Anne): So even when you have such a low threshold, you still are seeing about 3/4 of patients not even meeting that threshold, so.

Don Casey: Right.

Male: Good point.

Don Casey: Very good, so it looks also like there was a balance that favored continued endorsement. I think there are some issues that might have maybe be less so now that we're going to get some clarification, but I'll ask the NQF team to be sure that we've documented all of these and maybe feed them back to the people on this call to be sure we didn't miss anything in terms of what we want to - some of the homework that we've got to do between now and our meeting when we vote on these.

I know it's just one minute past the hour, so first of all thank you all for taking across the finish line and thanks to our partners. Lauralei, do we have anyone on the call for public comment? I know we're a little bit late.

Lauralei Dorian: No, that's okay. Tulare, are you there? Can you check to see if there is anybody on the line?

Operator: Yes I am, it does not look like there's anyone on the line for public comment.

Lauralei Dorian: Okay.

Don Casey: So just remember folks that public comment, this is not the last time we'll be asking for public comment. And once we get public comment that's when the fun starts. So you're just doing the leg work to getting us into the arena. So again thank you.

I want to point out too that the NQF staff have been working really hard on this project and (Jerry Lam) and I have been talking to them almost on a weekly basis. One thing that will happen very soon is you'll be getting a memo.

And one of the things we're going to ask you to do which you might want to do now is again you -- my pet peeve -- go back to those initial NQF endorsed care coordination preferred practices and we're going to ask you some key questions. We're not going to ask you to go in and micromanage what we wrote, but we are going to ask you some key questions that related to implementation and whether there are any new gaps in this list.

And the other idea is to perhaps maybe given that we didn't have any real new measures submitted, make an attempt to see if we could structure this along the lines of the NQF site practices or tide of care standards or health care disparities where we could potentially ask others

like NCQA to turn these preferred practices into sort of a checklist assessment for organizations who are trying to document their progress and journey with improving care coordination's.

So these are going to be worn out in our discussions when we meet as well because I think once we hit a rhythm on these measures that we're doing the pre-work on, I think we're going to have some time to really look past the endorsement of these into the future.

So are there any final questions or comments? Lauralei, did you get everything you needed here?

Lauralei Dorian: We did, yes. Thank you, thanks everybody.

Don Casey: Good. So thanks to everyone and thanks to our partners for being on the call. And again, this is not the final discussion. If there are any new ideas that you have, please continue the dialogue and send those to Lauralei for additional enhancement to our discussion, so.

Lauralei Dorian: Yes and a reminder that you can use the SharePoint discussion forum as well.

Don Casey: Yes, please use the SharePoint.

Lauralei Dorian: And if you just want to go back in and re-rate any of these measures or any of the other measures before the in-person.

Don Casey: Yes, I would encourage you if you want to go back and tweak those, please do that if you want.

All right, well thanks to everyone for great work.

Lauralei Dorian: Thank you, yes.

Don Casey: And we'll keep the ball rolling here. Take care, bye bye.

Lauralei Dorian: Bye.

Operator: This concludes our conference call...

Don Casey: Lauralei, do I need to stay on? Hello?

Operator: And everyone, that does conclude our conference call for today. Thank you all for your participation.

Don Casey: Oh okay, never mind. All right.

END