NATIONAL QUALITY FORUM

Moderator: Lauralei Dorian
February 13, 2012
12:00 pm CT

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

Lauralei Dorian: Thank you, good afternoon everyone and good morning to those on the west coast. This is Lauralei Dorian and here with me are Evan and Karen, and I'll just check to see who else is on the line.

Female: Can you speak a little bit louder, please?

Lauralei Dorian: Sure, sorry. This is Lauralei Dorian from NQF so he's going to do a brief roll call to see who's on the call. We have Evan Williamson and Karen Johnson from NQF and Karen Pace is here on the call as well, right?

Lauralei Dorian: Okay, we're going to go through the committee members to see who we have on the call. I think we have almost everybody but I'll just check to make sure. Kathleen?

Kathleen Aller: Yes.

Lauralei Dorian: Karen?

Karen Farris: Farris, yes.

Lauralei Dorian: Pamela Foster?

Pamela Foster: Yes, here.

Lauralei Dorian: Great. Christine Klotz?

Christine Klotz: Here.

Lauralei Dorian: Linda Lindeke?

Linda Lindeke: Yes, I'm on, thank you.

Lauralei Dorian: Great. Alonzo White?

Dr. Alonzo White: Here.

Lauralei Dorian: Great. Anne Marie? Anne Marie, are you there?

Anne Marie Audet: Yes, I'm here.

Lauralei Dorian: Yes, we can hear you, thank you. (Phil), are you there as well? He might be calling in and then I'll also just check to see which measure developers we have on the phone. CMS?

Keziah Cook: Keziah Cook from Acumen is here representing two of the CMS measures.

Lauralei Dorian: Okay, great, and NCQA? Anybody from NCQA on the call yet? All right, we'll wait for them to call in. Those are the last two measures to be discussed anyway. Thank you for your participation in the call today.

Just a reminder that this call is being recorded, so we will be taking public comments towards the end of the call and if you can just keep your phone on mute when you're not speaking, that would be great so I'll hand the call over to Karen Johnson now.

Karen Johnson: Okay, this is Karen Johnson. I just wanted to go over real quickly the process for this call. As I'm sure you know, we asked a few of you to be the lead discussant for one of the measures so if you're the lead discussant, we would like you to summarize your measure and then just basically tell us what the measure is and then summarize the ratings and the rationale that came through on the preliminary evaluation.

And then after that, highlight the areas of concern and for the most part try to focus on the must-have criteria, not so much on the things that aren't the must-have things. After you do your summary, we'll ask other reviewers of that measure if they want to make any additional comments and then after that we'll just open it up to the group for discussion.

And as you know, there's developers are on the phone and we asked them to be available to us so that they could address any concerns that you may have that you want to ask in case you want more information or that sort of thing so hopefully they could be that for you.

And I also wanted to remind you that we only have an hour and a half to discuss four measures today and we do need to leave some time at the end of the call for public comments because the public may be on this call so in our hope today as NQF staff we basically have two roles.

One is we're here if you need us to help clarify the NQF criteria and guidance for the evaluation and also to kind of keep an eye on the time for you. Generally this is something that our co-chairs would do but unfortunately (Don) and (Jerry) both I think are traveling today to NQF headquarters tomorrow so they are not able to be on the call.

So I'll be keeping an eye on the time and if something happens that we can't quite finish the discussion, I will just remind you that there are other ways to continue discussion of a particular measure if we need to, e-mail and discussion forum on SharePoint.

So I think with that, does anybody have any questions first of all on the process for our call today? Okay.

Kathleen Aller: Is there for - this is Kathleen Aller - for those who are not able to get the screen-sharing to work, I'm assuming we should just follow along on the Excel.

Karen Johnson: That would probably work. That'd probably be your best bet if you have that available to you. The things that we have open and will be showing on the Webinar is the Excel sheets and if necessary we also have the measure submission forms open so you might have those handy too if you have those with you.

Kathleen Aller: Thank you.

Karen Johnson: Any other questions?

Karen Pace: This is Karen Pace. I was going to say those of you who are having trouble with the Webinar, you might try starting over four times and usually if it's the first time you've been on ((inaudible)) you may have to download some software. If your system prevents that ((inaudible)). That's the only ((inaudible)).

Female: It worked fine for me last time but it's not working this time.

Karen Johnson: And (Evan), why don't you make sure because I know everyone was notified of all three workgroup calls. Let's make sure they're on the right ((inaudible)) Webinar.

Female: I can confirm that because I inadvertently opened the wrong workgroup call and it very carefully told me it wasn't the right one so I can get in the meeting, I just can't see the sharing.

(Evan): Okay, yes, so yes, just to confirm this is Workgroup 3 and we have all the information is also available on SharePoint in case you don't have it in your e-mail so nothing that we're going to be going through isn't available so again do your best to try to get the screen-shares open but if not, it'll be very easy to follow along on the Excel spreadsheet and the measure submission forms.

Karen Johnson: Okay, any other questions before we get started?

Dr. Alonzo White: Let me just ask one question. When we present this information - this is Alonzo White - do you also want partner comments included or not?

Karen Johnson: It's up to you. If you want to read verbatim the first comment, that's fine or if you want to just do a quick summary of the major points, that would be fine as well.

Dr. Alonzo White: Okay.

Karen Johnson: ((inaudible)). Okay?

Dr. Alonzo White: All right, thank you.

Karen Johnson: Well with that, Alonzo, you're first on our list so do you want to go ahead and start with Measure 0171?

Dr. Alonzo White: Thank you. The 0171 is actually very similar to the 0173 and the measure is entitled Acute Care Hospitalization Risk Adjusted. It was - the measure steward - was CMS. Description of the measure is that it's the percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of a home health stay.

The numerator statement is the number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 60 days following the start of the home health stay and the denominator is the number of home health stays that begin during the 12-month observation period.

A home health stay is defined as a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days. The exclusions were home health stays for patients who are not continuously enrolled in fee-for-service Medicare during the numerator or 60 days following the start of a home health stay or until death.

A home health stay that begin with low utilization payment adjustment, home health stays in which a patient receives service from multiple agencies during the first 60 days and stays for patients who are not continuously enrolled in fee-for-service Medicare for the six months prior to the start of the home health stay.

This is an outcome measure. The data source is administrative claims and it's facility-based. This is not paired with another measure. Some of the staff notes are that this is designed to reduce preventable hospital admissions and readmissions and because this is an outcome measure, ratings quantity, quality, consistency, the body of evidence is not required.

However, developers should show that the rationale supports the relationship of the home health outcome or to process or structures of care. The admissions categorized as planned.

There was a memorandum that was sent around and that was actually found in Appendix A and they excluded - the planned admissions were found in Appendix A - and they're excluded unless they have a discharge condition category considered acute or complication of care and that was found in Appendix B.

Beneficiaries include continuously-enrolled those in Medicare fee-for-service Parts A and B for 2010 for the entire 60-day numerator window from the start of the home health stay or until death as well as six months prior to the start of the home health stay.

The impact of excluding this population is felt to be slight but it's felt to make the measure more fair. It has a slightly larger effect for females than males and the effect is considerably less for beneficiaries aged 85 or older.

When we actually go to the measure and we look at the first criteria - importance to measure and report - we had four yeses and one no. Under impact we had five high and one medium. Under performance gap we had five high and one moderate I should say.

There was one - a couple of comments - which I thought were important. The measure does address a specific national quality goal priority; however, I am not convinced that the measure accurately depicts the quality of the home healthcare agency as it does not link conditions for home health and for acute treatment.

The data does not link related conditions for both episodes of care. Also the data submitted does not account for disparities in care by population groups other than perhaps some dual eligibles.

Under evidence we had four yes and one no. For health outcome we had three yeses and one not applicable and then for those who went on and evaluated the other measures, the two people that we had one high for quantity and one moderate. One high and one moderate for quality and for consistency we had one high and one low.

Under scientific acceptability of measure properties we had six yeses and zero nos. Under reliability there were six yeses, under validity six yeses, couple of just pertinent comments.

The home care agencies are helpful and understanding which diagnostic groups are hospitalized more frequently but in my estimation does not address the concern as to whether or not these diagnostic groups are related to the home health groups.

I think this is the same argument we heard before. The risk adjustment is helpful in keeping higher-acuity diagnosis from overinflating the rate; therefore, the risk adjustment strategy in its current form is helpful in circulating more a true number in the measure's current form.

Under usability we had four high and two moderates and that actually measures meaningful, understandable and useful and if the measure's useful for its intended audiences and then again it's the same reasoning that was given for the other reasons - disclaimer that was given - for the other two criteria.

Under feasibility we had six high and so everybody agreed and that actually basically looks at is the clinical data generated during a care process. It looks at is it electronic? Is this susceptible to inaccuracies and can the data collection strategy be implemented?

There was one comment that I thought that needed to be noted and that was it requires special knowledge to compute. Claims lagged differentially and caused some delays in calculations.

But I also might want to point out that this will be reported quarterly so what's not captured in this group may be captured in the next group so the preliminary assessment of the criteria for endorsement, we have five yes and zero nos.

And then the comment I thought that was pertinent was this measure has been publicly reported in the last few years to gauge quality of home health agencies and could based on a handful of studies be used to gauge quality of inpatient care coordination.

I do not as previously mentioned think that the measure would be more beneficial if correlation was made for diagnosis of each episode. In my experience this analysis tends to cut the rate by a significant amount. Any comments, questions?

Karen Pace: This is Karen Pace and Karen maybe we should have give a little status report because this measure is still - the final risk model - is not finished yet. Do you want to just say a few words about that just to kind of keep things in context?

Karen Farris: Sure. Part of the staff ((inaudible)) I had let you guys know that the risk adjustment model that is available in the submission is not the final model but we have heard from the developers from CMS and they had given us several different pieces of information.

Unlike what they had thought when they first submitted the measure, they have decided against including any of the Oasis variables in the risk adjustment model so that was one thing that was of concern and they will not be doing that right now.

They are looking into potentially adding-in some interaction terms into the risk adjustment model so what you have in front of you may not be the final model. They are planning to drop the dual eligibility variable from the risk adjustment model and also they will probably - they're planning to I believe - modify the measure so as to exclude planned hospitalizations.

And to give you more information about that on Friday I believe they shared with us a memo that gives some information about what that change would do to the measure score and we shared that with you I think on Friday so those are the changes from what you saw on your measure submission form.

Female: So this is ((inaudible)) so I just want to make comments about the dual eligibility and then the I think CMS and their developer is also on the line if you have any specific questions for them.

This is to be consistent with their policy and also NQF guidance on risk adjustment to not adjust for factors that are related to disparities and if disparities is an issue, then there can be discussions about how the data are reported but generally the NQF criteria guidance is not to include disparities-related factors in the risk model.

And that's also been CMS policy but we'll be looking - they'll be sending us and you all - the final risk model so you can see show those factors, you know, what the final model looks like and the performance metrics on that model.

But for the - one of the committee reviewers - made some comments about or had a question about the home health episode diagnosis versus the things that are in the risk model so maybe we could hear a little bit more about that and if you have a question we could ask the developer.

Pamela Foster: Yes, this is Pam Foster and I was the individual who raised the concern about the diagnosis correlation and so if in my estimation just in kind of trying to read through how the risk adjustment model was applied, I couldn't quite - it wasn't fleshing out for me - how that would account for the related versus non-related but if that's what it's meant to do then I would appreciate an explanation of that.

And then I also have a second question as to the taking out the planned admissions and wondering if that's been done through leave-of-absence billing or how did they determine that it is a planned admission?

Karen Johnson: Okay, and just to clarify before we have them respond, when you're talking about related versus non-related, what specifically are you asking about relation to?

Pamela Foster: Well, in my reading through the measure, the acute care hospitalization or the or, yes, the acute care hospitalization was meant to - it's a quality reflection - on the home health agencies so in other words if the patient is being managed appropriately and well in the home health setting, there shouldn't be an acute - one would hope there wouldn't be - an acute care rehospitalization.

But if the rehospitalization is due to another diagnoses for which they're not being treated for under the home health episode, you know, I'm not sure that that's necessary a reflection.

So for example if a patient is enrolled on home health care for heart failure and, you know, they slip on a wet floor and break their hip and are readmitted, that isn't necessarily a reflection on the management of the home health agency.

Karen Johnson: So we'll let CMS and their developer respond. Just one overall note is this is the same way with the previous home health hospitalization measure and the readmission measures that are being applied to hospitals is that it's pretty much all cause readmission, not trying to separate that out because it becomes a very difficult task from a reliability standpoint.

Pamela Foster: Yes.

Karen Johnson: That is a reason to exclude planned readmissions and we'll ask the CMS and their contractor to also respond about trauma so I'll stop there and just ask if either CMS or their contractor wants to respond to these questions about...

Keziah Cook: Hi, this is Keziah Cook from Acumen and I'm happy to respond. Can you guys hear me okay?

Female: Yes.

Keziah Cook: Okay, so I guess I just really wanted to make two notes. The first is - I'm sorry, I'm not sure who I was talking, Karen maybe - this is an all-cause hospital admission measure as is, you know, the analogous measure for hospital readmissions and as was the older Oasis measure.

And the thing to keep in mind with all-cause measures is we don't expect home health agencies to have 0%, you know, doing well on preventing acute care hospitalization will not result in 0% of patients have hospitalizations, you know, this is often a frail, elderly population and there are going to be, you know, acute events requiring hospitalization that the home health agency could not prevent.

That said, there's a lot of variation across agencies in the fraction of their patients that are hospitalized and that's true even after controlling for the patient characteristics and there's also reason to believe that while home health agencies can't perfectly prevent acute care hospitalization, they can have some impact.

So an agency that's providing high-quality care, actively monitoring their patients, communicating with their patients about appropriate ways to seek care if something unexpected happens will tend to have lower rates of acute care hospitalization than an agency that, you know, shows up every couple of weeks to do physical therapy and otherwise just ignores the patient.

So that was just the first thing I wanted to make clear about the all-cause measure. You know, and then just in terms of what the risk adjustment is doing, the risk adjustment is accounting for patient characteristics that exist prior to home health care so if a patient has a diagnosis for heart failure prior to receiving home health care, then to the extent that that diagnosis increases their expected rate of hospital readmission then that'll be accounted for.

It doesn't mean necessarily the home health agency was charged with only treating heart failure symptoms, you know, the view CMS takes about home health is that the whole patient is being treated so yes, heart failure might be the most significant condition but the agency would also be, you know, assessing the patient's other needs and providing for those needs appropriately.

Kathleen Aller: So this is Kathleen Aller and I apologize. We had some family circumstances that prevented me from entering my presurvey but when I reviewed the measures, I was a little concerned that the only evidence cited that's really linked the readmissions with the home care was really around interventions related to TeleHealth.

There was one other one and you state much broader indications of relationship but there was a fairly limited span of evidence cited in the measure specification and that concerned me a little bit.

Keziah Cook: Is Liz Madigan on the line? She also has been working as a developer on this measure.

Elizabeth Madigan: I am.

Karen Johnson: Maybe she could speak to the lit review.

Elizabeth Madigan: I am on the line.

Keziah Cook: So from the literature review part of what we were trying to do and this is always a delicate balancing act is to try to get the evidence that's most relevant to home healthcare where we actually have indications that the home health care, there's actually relevance to the home healthcare population.

So we either tend to have very few studies or we have so many studies that are community-dwelling elderly so I was trying to actually identify the ones where we actually had the most evidence for home healthcare patients. There is some evidence that if there are physician visits of course follow-up physician visits that will help, that's one of the interventions.

Care coordination and care transitions is another one but again most of these haven't been applied specifically to home healthcare populations but the populations that are similar to home healthcare patients so that may be why you're seeing sort of an imbalance in the literature review.

Karen Pace: And this is Karen Pace again. Just to clarify NQF criteria, we - for an outcome measure such as this - we don't require that they submit all of the bodies of evidence.

We ask them and we may need to work on this just a little bit but basically the idea is is there rationale that and meaning not that they submitted a formal rationale but in looking at the connections between healthcare, structures, processes and services and institutions that can effect this, is there reasonable rationale that healthcare does affect readmission rather than asking you to evaluate or asking the developer to submit the quantity, quality and consistency as a body of evidence.

Because there are usually multiple processes and structures and intervention in effect an end result outcome or a health outcome such as readmission as when you think about readmission being a deterioration in health status - a proxy for due care (ratio) health status - that's why it's been classified as an outcome measure not requiring that body of evidence.

But it still does require that you all as a committee think about, you know, the healthcare structures, processes and services that affect that but Keziah could you address the admissions for trauma? Is there any...

Keziah Cook: Oh right, I'm sorry. I missed that part of the question. Right now we haven't implemented an exclusion for trauma in part because, you know, in part because this really is an all-cause measure and we were trying to stick pretty closely to how all-cause admissions have been defined in other contexts.

So our exclusion for planning admission actually applies the same criteria as was used for the recently-developed hospital readmission measure and that measure did not have a similar exclusion for trauma.

And, you know, from a practical standpoint at various points in our development process we did look at trying to exclude, you know, hospitalizations resulting from injury or something along those lines and it's honestly very difficult to determine which admissions are due to sort of what they're calling trauma and which admissions are actually due to significant deterioration in the patient's status or a lapse in appropriate caregiving.

Karen Pace: And this is Karen Pace 112, had a comment about that is the trauma events, you know, unexpected trauma or totally unrelated things should occur in a pretty much random fashion and not be concentrated across one agency's patients.

So ultimately that really shouldn't affect, you know, your standing in terms of other agencies as because I was talking about in terms that, you know, as you know we don't ever expect this to be 0%.

Pamela Foster: Sure, and how - this is Pam Foster again - how were the planned readmissions being calculated then? Was it through leave of absence billing or how are you doing that?

Keziah Cook: The planned exclusions are calculated using a code list based on the RCCs. If you received the memo I think Lauralei circulated the precise code you listed in the two appendices.

The basic idea is there are certain procedures that are considered to be planned so this would be, you know, a procedure where a patient would plan a procedure with their doctor in advance, be required to go into the hospital to receive the procedure and then be discharged to their home so the fact that they were hospitalized is an appropriate course of care for that patient rather than signaling an adverse event.

The precise code lists were developed by a group at Yale as part of the hospital readmission measure that I think NQF considered last fall and we've used the same definitions because the group at Yale did significant work, you know, clinically reviewing and vetting those code lists.

Pamela Foster: Okay, thank you.

Karen Johnson: So a classic example would be readmission for cancer chemotherapy; is that correct, Keziah?

Keziah Cook: Yes, that's right, exactly.

Pamela Foster: And I think that I just want to - this is Pam Foster again - I just want to say that this information had come after I had reviewed the measures and I think it does help toward vetting out those unrelated readmissions. I think that's a huge step in getting more to the true number of related readmissions.

Keziah Cook: Right and we're sorry about the timing of things, this group trying to work with CMS and the developers so that this measure can actually be acted upon in this project but, you know, if they had been still in the development work but, you know, it's...

Pamela Foster: Sure, yes.

Female: So this - go ahead.

Karen Johnson: I was just going to ask if there were any other questions or concerns about this measure that they wanted to bring up right now. Are you ready to go on to the next CMS measure? It is very similar to the ACH measure.

Dr. Alonzo White: Let me just make one other comment about this - this is Al White - I think this actually measures more than just the effectiveness of the home health agency and the quality. I think it also is a measure of care coordination, discharge planning, all of those things sort of play a role in this so this could be maybe used as a proxy for other things as well.

Karen Pace: That's a good comment - this is Karen Pace again - and it is seen as that really promotes shared accountability because of those things you mentioned in terms of care coordination ((inaudible)) and certainly, you know, the home health agency has a role in that but it's not the only player in that so that's a good observation.

Karen Johnson: Okay, well with that why don't we go ahead and go on to Measure 0173, emergency department use without hospitalization. That also...

Anne Marie Audet: This is Anne Marie. As everyone noted, it's very similar so here the measure is the percentage of home health stays in which patients use the emergency department but are not

admitted to the hospital during the 60 day following the start of the home health stay so the numerator statement, you know, mirrors that definition.

Denominator exclusions are very similar to the one on admission and this is an outcome measure and what I'll do here is, you know, go through the must-pass measures and just pick-up some of where the committee or where the raters made some comments that are relevant to the discussion.

But basically because all the others, you know, the claims data and all this other is very similar to 171 so if you look at the importance of the measure in terms of impact and performance gap, here we had five high and one medium and one low and there were two comments.

One was that the population affected by this when you do the calculation could be quite low because the ED visit without prior hospitalization is about 10% of the population and so if you make the calculation, really we're impacting a small number so that person actually rated the impact as lower than others.

And the other comment that was made is again very similar to Measure 171 in terms of whether this measure really qualifies as rating the quality of home health because of not excluding non-related diagnosis which we were just discussing.

The scientific acceptability of the measure in terms of reliability and validity, reliability was all high seven and the validity, five highs and two mediums and in the comments that were provided, I wasn't sure why the two mediums because I didn't - the medium rating - didn't come up as an issue really in the rationale.

But I suspect that the person who also was discussing the issue of the non-related diagnoses probably gave a lower validity score but we can hear that from that colleague when time arrives for the discussion.

In terms of usability, there were four highs, two mediums and one low and the one low, the comment here was that the information is presented on the methods used to assess the usability such as focus groups with consumers, external advisory workgroups with consumer advocacy organizations, provider organizations, QI professionals.

The measure developer also noted they did a literature review of published papers that assess consumer comprehensive and use of the reported measures but in the submission of the measure, the developer did not really give any results of the findings about that.

And then I think there was another issue about usefulness about poor - that the developer - did a poor job relating the usefulness to the quality of the home health agency again whether this measure is a valid representation of home health quality.

The feasibility, six highs and one medium and again the medium rating I'm not sure except that there was one comment saying that there's a lot of experience needed to calculate based on the claims data so that might be the reason and in terms of meeting suitable - the criteria suitable - for endorsement, we had six yes and one no.

And there was a comment that this measure will give useful information of the quality of the discharge planning and possibility of the process of case management. That concludes my short summary. Hello?

Karen Pace: This is Karen Pace and I'll just make one comment. I haven't looked at this in detail yet but the potential reason for the difference in the rating of reliability and validity could be that in our

rating scale the high rating is reserved for measures for which they've done appropriate testing at two different levels of the actual data elements used and the measure score.

So I'm not - it doesn't necessarily refer - to the how good the reliability statistic each, you know, whenever it's tested it needs to meet acceptable reliability but that may have been and I don't know if any of you can talk about that but that could have been a reason for the difference as we're getting used to these rating criteria.

Karen Farris: This is Karen Farris. I would just add that I didn't quite rate it that way on my original but can do so later so just I think I didn't write it exactly the way you just said.

Karen Pace: That's okay. This is we're all learning how best to apply those criteria. It's something that we need to do better in clarifying for everyone but I think that could be one reason.

Female: Can we get someone to ask the question about because actually that was my question about more evidence about usability and how these measures have been used by either consumers or providers for quality improvements?

Keziah Cook: This is Keziah from Acumen and I may need to defer to one of my colleagues but the usability testing that's been done for the home health quality measures I guess it most directly referred to the sort of earlier versions of these measures that were specified using Oasis data but I think from the point of view of can a beneficiary understand, you know, is a lower rate of emergency room use good or bad?

What does that tell us about the quality of the home health agency largely applies sort of regardless of the data source so that testing was done by L&M a couple of years ago and it was focused really on preparing the measures for the home health compare Website. Is (Deb) Deitz on the line?

Deborah Deitz: Yes, I am. Can you hear me?

Keziah Cook: I can, yes. Can you say a little more about that?

Deborah Deitz: Well, I know that the way that CMS approached this issue in terms of wanting to ensure that the measures were understandable to the public and to consumers and families who would be using them is to work with a group of experts as detailed in the form there and to, you know, successfully approximate what would be the ultimate or most preferred version of the wording that was understandable worked with consumers and small groups to try to maximize the understandability.

So I don't believe that there were any results that came out of that in terms of, you know, percent of people who found it satisfactory. It was more as I said, you know, using the results of that feedback to create the wording that was felt to be the best that they could develop. I don't know if that answers your question.

Female: Yes, thank you.

Karen Johnson: Is there any other questions or concerns with this measure that you guys want to discuss at this point? Okay, doesn't sound like it. We're actually running way ahead of schedule which is surprising.

Female: Those are the easy ones.

Karen Johnson: Right now I'm not even sure that we have NCQA developers on the line. Do we have anybody from NCQA on the call at this point? Okay, well hopefully they will join us very soon.

We already have a call and an e-mail in to them so I think they probably thought it would take us a little bit longer to get through the first two measures but with that said, Karen Farris, do you want to go ahead and introduce Measure 0554?

Karen Farris: Sure. I'd be happy to. Can everyone hear me or do I need to speak louder?

Karen Johnson: You're good on this end.

Karen Farris: Okay, so this is a measure from NCQA. It is the percentage of discharges from January 1 to December 1 of the measurement year for members 66 years of age and older for whom medications were reconciled on or within 30 days of discharge, okay?

It's of course a process measure and the data sources are - I think I just want to point this out - I think it might come back up in feasibility are administrative claims, electronic clinical data, electronic health records and paper records.

So I'm just going to now go straight to our summary about the criteria. In terms of looking at the importance to measure and report, there were two yeses and four nos. I was among one of the yeses and can speak to that as we move on.

In terms of impact, most people did think that this was an impactful measure - five were high, one was medium - and I think there was some in terms of the performance gap though there was some disagreement.

Two said high, two said medium, one said low and one said insufficient so certainly are trying to understand the data that is available and is there really an issue I think we'll be discussing here in just a little bit.

And then of course I think we're going to be talking about the evidence 1C where there were three yeses and three nos and I think we will be referring to Table 3 where the quantity, quality and consistency are going to be relevant here.

In terms of quantity, two people said high, two people said medium, one low, one insufficient or I - what's the I for, I forgot - anyway on quality, two high, three low and consistency one high, three medium, one low so depending on how you rated that, you would then give your rating on the past subcriterion and so that's where we certainly see some variability, three yes, three no.

I'm going to move on to scientific acceptability where we have three yes, one no as our overall vote. In terms of reliability, three said high, one said medium and then in terms of validity, one said high, two medium and one insufficient.

Let's see. I think an important here is that validity was tested with a panel of expert stakeholders with specific expertise in measurement. For reliability, they talk about multiple data sources were used. Actually these are some of the comments that we're making about the measure.

One of us said there's not a systematic review of the evidence and so then again we're relying on face validity. There's no explicit link to outcomes. Let's see, one question about the exclusion of readmission since lack of med rec may actually affect readmissions.

In my view the range of the reported measures was 31 to 34% in the three years of reporting but then that was the mean of this measure but then the range was zero to 97.

I'm going to move to usability where four people said it was high, one medium, one insufficient information. Some comments. This is useful for health plans using (heatus) and NCQA accreditation.

Usefulness in other settings is less clear. Someone wrote it's easy to interpret. The calculations are clear. Okay, I'm going to move on to feasibility which we also have some controversy, high two, medium three.

And it says that it's compiled on an EMR during patient encounter. Measure developer says all information is in the EMR but yet they talked about paper claims so that's a little unclear.

The required data elements - post-discharge, med rec - was not defined as being routinely generated so again I think we're saying, you know, is this data available even though the measure developers are asserting that it is.

Let's see, okay, and then just a final overall assessment, three yes, three no so we're split right down the middle. The linking of clinical outcomes like readmission to administrative process of med recs following discharge is complex so your results are mixed.

The quality of evidence - here's another comment - the quality of evidence of this single specific step is limited. Reliability is strong so if it happened, we at least think that we can see it happening. The validity is only face validity. It seems to be usable. Feasibility is not clear.

Overall this measure's important for multiple reasons as cited by the evidence and while in and of itself it is not linked with specific outcomes, it is a process measure that relies on strong evidence-based research and then this would be my final comment.

This measure will not cause harm and so I guess that got me back to our evidence - the evaluation of evidence - I would be thrilled to be convinced the evidence is stronger than I think it is so we can endorse this process measure.

It is a measure that if not done can result in rare serious consequences so that's my presentation of this measure.

Lauralei Dorian: Thanks, Karen; just quickly - this is Lauralei here - Felicia, are you there? Is the operator there?

Operator: Yes.

Lauralei Dorian: Okay. I think NCQA has dialed-in. They are developers and they're meant to be on a speaker line. Are you able...

Operator: If they would like to speak, they can go ahead and press star 1 and we can open their lines and again if you have a closed line and require an open line and we can open Dawn Alayon.

Dawn Alayon: Hi, can you hear us? This is NCQA.

Lauralei Dorian: We can hear you, yes. Thanks, Dawn.

Dawn Alayon: Okay, great. Sorry, we've been shouting at this phone for quite awhile now.

Female: ((inaudible)).

Dawn Alayon: Okay.

Female: Yes, do you want to just go ahead and maybe I guess pick one of your first comments that you want some more clarification on and we'll just go with it?

Dawn Alayon: I think that some of that - we appreciate first of all you guys reviewing this measure - this has been a measure that we've been collecting through (heatus) for quite awhile now.

Female: Can you talk closer to the microphone, please?

Dawn Alayon: Yes, I'm sorry. Can everyone hear me okay now?

Female: Yes.

Dawn Alayon: Okay, great so I just wanted to say thank you for reviewing this measure and considering it. We're going to respond to - I hope that I can remember - all of the various comments that were brought up but please stop me if I'm going off track.

So I want to just start by clearing-up a couple of things that may have not been entirely clear in the submission form. First this is what we call a hybrid measure which can be collected through either - hello?

Operator: Please go ahead, your line is open.

Dawn Alayon: I'm sorry so this is to be collected through either administrative data meaning through a CPT2 code or it can be collected through electronic health records if those are available or it can be collected through medical record review.

This method of collecting the ((inaudible)) are - I'm sorry, there's a lot of static on the line - I'm just making sure no one's trying to interrupt me or that we're still connected.

Operator: You're still connected. Please go ahead.

Dawn Alayon: Okay, so the hybrid measure is something that is we have several of these measures in our (heatus) dataset and they have been collected through several years so where it says that this was all data elements are electronic health records that must have been a box that was mistakenly clicked because this can be collected through medical record review, administrative data in terms of CPT2 codes or electronic medical records.

So hopefully that addresses some of the questions about feasibility. In terms of usability this is a measure that is specified for a health plan so we don't really intend for it to be usable at different levels because it really is on the health plan level.

There are other measures which address medication reconciliation at different levels of accountability so in this measure we're really aiming at ensuring that everybody who is discharged has a medication reconciliation within 30 days of discharge so I think that was usability, feasibility.

Going back to the exclusions for readmission so once again this might have been something that was not entirely clear in the form. Basically our exclusions say we don't count discharges to other facilities so it's mostly looking at a discharge to the outpatient care.

And the reason for that is that we don't really expect that the medication reconciliation with the patient outpatient medical record needs to happen until the patient has been discharged to the outpatient setting so if a patient's going from say the in-hospital stay to rehabilitation, this doesn't necessarily apply until the patient has been discharged from rehabilitation.

In terms of the exclusion for readmissions, I think that basically that exclusion is that we only count one discharge I think and (Don) correct me if I'm wrong here one discharge per 30 - sorry, no, we do count multiple discharges - per 30 days.

So if someone is discharged from the hospital, is readmitted and then discharged again, both of those will count in the denominator so finally getting to the evidence, you know, we struggled with this literature review because part of the problem with the evidence for this is that medication reconciliation is not something that is defined consistently and measured consistently across studies.

And so the real problem with showing the evidence for this has to do with the quality of the studies that are out there so despite the fact that there is a hard systematic review, you know, saying this must be done, this is still something that physicians feel is very important.

Hospitalization due to adverse medication events that occur when people are discharged without reconciled list is a huge healthcare driver - a healthcare cost driver - and results in very adverse outcomes for patients.

So while the evidence may not be there, we believe that's more a statement about the quality of the studies that are being done on this rather than the importance of this actual process so I'm going to pause now and I'm going to let - I know I went through a whole bunch there - so let people ask additional questions.

Kathleen Aller: This is Kathleen Aller. One of the things that struck me is that and this is consistent with what you just stated, in the document describing the measure stewards evaluation of the evidence, you actually do rate it fairly low and yet my colleague has in many cases rated it much higher and I wondered as a group how we kind of reconcile against that.

Also in some cases even though the evidence for the two med reconciliation measures we're going to be considering is identical. In some cases we're rated it differently across the group so I guess I'm looking for discussion amongst our group on that.

Karen Farris: This is Karen Farris. I may have rated them differently because the other one is a 60-day measure in the physician office explicitly I believe and this one is not so I was probably a little more generous in this one than the other one, than the one in the physician office.

I didn't think there was as much specific evidence about that but, you know, I'm very open to hearing what I may be ignorant of so but that would be my view of maybe why I thought of why I did think of these a little differently.

Christine Klotz: This is Chris Klotz. I thought of them differently too because of the timeframe, you know, a lot can happen in 60 days especially if someone is frail or declining or has, you know, all kinds of things can happen in 60 days so it really seemed to me that if you wait for 60 days to check on their medications, they could have been hospitalized several times in-between because of a medication problem or something else.

Karen Farris: Yes.

Female: So maybe I'm not understanding the process well. I thought we were rating evidence that's cited in the specification rather than what we know about the process.

Karen Pace: Yes, this is Karen Pace.

Female: And the evidence is literally identical between the two. I'm sorry, go on.

Karen Pace: Right. I just was going to clarify. I know that what we had discussed with the steering committee is to rate this based on the evidence presented in the submission. I think that's what you were referring to.

Female: Yes, and I'm trying to understand process here.

Dawn Alayon: We all are, yes, it's all good.

Female: Right, so but obviously you all as experts in the area may be aware of other evidence and that certainly can come into play into your final decision but when you were individually looking at this just to get a sense of where things were at with the evidence that was presented and then, you know, certainly to identify if there was other evidence.

But maybe we can ask the developer because I'm not sure based on this. Dawn, you referred to a systematic review of the evidence but what are you referring to as the systematic review of the evidence?

Karen Pace: That was those four RCTs and the primary endpoint was 30-day readmission, wasn't it?

Dawn Alayon: So yes, there were RCTs I believe.

Female: But could you tell who did the systematic review of the evidence?

Dawn Alayon: I don't think that there is a systematic review of...

Female: We did not say a systematic review of the evidence. We said that our review of the literature was challenged because of the heterogeneity in the way that the intervention was described across the different settings and across the different studies.

Karen Farris: The (Hanson) reference is the one - this is Karen Farris - I'm referring to that is a systematic review but it's linked to a primary outcome of 30-day hospitalization which I think is a high bar for a single med rec but that's my view. It's the (Hanson) on page 6 of the application, there's a (Hanson) reference in archives of internal medicine.

Dawn Alayon: Right, so this is the NCQA team. I don't have that article directly in front of me. That is not a systematic review of med rec interventions. That's a systematic review that looked in general at interventions to reduce readmissions or to reduce ((inaudible)).

I would need to pull that article to pull the exact review that they did which like I said I don't have in front of me but I would be happy to come back to the steering committee with that information more specifically.

Karen Pace: So this is Karen Pace and we'll ask the committee this and then you can ask the developer if it's helpful. Generally if a systematic ((inaudible)) the evidence has not been done, if maybe that's the first question is if anyone - if there has been - systematic review of the evidence or ((inaudible)) reconciliation is any of the steering committee aware of such, a review of the evidence?

Female: No.

Female: No.

Karen Pace: Okay, so then because that's really what we're trying to get at so then we don't really have a body of evidence. We have these isolated individual studies that the developer tried to pull together.

So it probably does not meet our evidence criterion but this is something then that you all would need to think about as to whether this topic was important enough or there were enough individual studies pointing to this that you would want to consider an exception to the body of evidence or as a, you know, expert opinion or that there was enough evidence that it was worthwhile in a performance measure.

And I think maybe you can have some discussion about that. Did the developer cite the correct studies that you all are aware of about medication reconciliation? Are you aware of other kinds of studies?

Karen Farris: This is Karen Farris. I'm aware of a few additional studies.

Karen Pace: Okay but again it gets back to this same point. NCQA is saying that it had med recs plus some other transition-of-care activities and so to find one study focused just on med rec, I'm not even sure it's possible.

Karen Farris: Right, right, okay, well that's I think important for you all to know and recognize and so, you know...

Karen Pace: Unless they're just descriptive studies, you know, saying here's the discrepancies we found but just evaluating that single intervention is it seems limited from a person who does research so I'll hush now.

Karen Farris: I hear what you're saying and I guess one of the questions that you all wanted to ((inaudible)) if medication reconciliation has not really been studied in isolation as part of a package of things, does it make sense to have performance measures focused-in on a single aspect and it's just a question. I'm not trying to say one way or the other.

I'm just trying to kind of ask you where there is evidence and what the evidence points us towards.

Dr. Alonzo White: This is Al White. I think intuitively most of us think that this is the right thing to do and it probably does help but again the data's not there to use it as a standalone item so I guess from

my mind the question is just as you said, do we want to use this as a standalone item or should this be paired with something else or not used at all?

Karen Farris: Great question. I think that the data show that it's not even always done and so if we think that it's a minimum activity, then maybe it should remain a standalone measure because the average was 30%, right, and so that's pretty low to me.

Dr. Alonzo White: But that probably correlates with my real-world experience.

Karen Farris: Yes, I would agree.

Pamela Foster: And this is Pam Foster. I echo Dr. White's comments, you know, I think that the body of evidence presented I want to say was adequate and I think that, you know, in terms of rating this I really am relying on my, you know, professional knowledge and skill and the intuitiveness of knowing that the consequences of what happens when this isn't done.

Karen Farris: Good and that's what we, you know, need you as a committee to do when we're in these situations then I think care court is one of those where, you know, the specific elements may not have a body of evidence or, you know, it may be difficult to assemble it or change out those individual things.

Karen Pace: Yes, I think we're, you know, coming down to one of those exceptions in that, you know, the potential benefits outweigh the potential harm and, you know, that's kind of where I came down in the end.

Dr. Alonzo White: Can I ask NCQA one other question? When you don't have electronic records are you going to use a sampling type of methodology to get this information?

Dawn Alayon: Yes, this is NCQA. Yes, we have a process for all of our (heatus) measures which are this hybrid where it's a sample of medical records.

Dr. Alonzo White: Thanks.

Female: Hey Dawn just mentioned that this was a health plan measure but it was submitted that it would be used as the down to the individual clinician.

Dawn Alayon: So this is an initiative that we have with all of our measure submissions in that (heatus) measures are specified for the health plan level. That is the level at which we collect the data. That's the level at which we validate the data; however, they are used by the health plans to assess their performance and individual practices and by individual providers.

We have no control over how the health plan uses this information once it's all collected and distributed so in that sense, it's currently being used by providers or by health plans at the provider level. That is not how we test our measures so that's really up to NQF as to how they want to label this measure.

Kathleen Aller: So this is Kathleen again and I don't know if this is an appropriate time for this question but I think it's triggered partly by what you're saying. There's also statements about harmonization in Section 5 and it says it (could be) aligned and harmonized with similar measures and one of the similar measures is 97 which is the other one we're going to be looking at.

And I fail to see how they are harmonized since they use different age groups and different definitions. Given that as you've just pointed out, this measure is not really intended for the individual physician level and potentially the other one is, don't we need to harmonize them more tightly in order to ensure that the data is aligned especially since we have so little evidence, we'd want to collect it?

Dawn Alayon: So this is NCQA again. I'm happy to talk about that right now if the moderator would like me to or if you want to hold off on the discussion of harmonization until you go through Measure 97 so I'd leave it up to the moderator.

Karen Pace: This is Karen Pace. I think, you know, we may not get into a big harmonization discussion. I think the question to you is you said it was harmonized but it seems quite different so ((inaudible)) say on what basis you were thinking this ((inaudible)).

Dawn Alayon: So these measures are actually you need to think of them more as different stages of medication reconciliation so they have different accountability so one is accountable to physicians and one's accountable to the health plan and they have different levels of intensity of medication reconciliation.

So one of the problem that we've heard from physician-level measures is that having a measure that's within 30 days have a patient come in for an outpatient visit is sometimes difficult.

Patients can't always get in and that the sample size just becomes really too small when you look at it at 30 days alone which is why the physician-level measure is at 60 days.

However, we felt it was still important that there be a measure of medication reconciliation by 30 days given some of the reasons cited earlier that in 60 days a lot can happen.

So what you need to do is think about these measures as the Measure 5 - sorry, I don't have it - 554 looks at medication reconciliation within 30 days by an RN, a clinician, a prescribing practitioner.

This doesn't have to be the primary care physician but it just needs to be a review of the medications in the outpatient record and from the discharge list within 30 days. This can happen over the phone. Really there's not a very high threshold for this one.

The next step would be an in-person reconciliation which is that when the patient comes in for the outpatient visit with their primary care physician or other physician who's responsible for their care, that physician is then responsible for once again reviewing the medications and making sure that the medications are appropriate for long-term care of the patient's condition.

So in this way they are harmonized ((inaudible)) seeing there's a significant levels of intensity ((inaudible)).

Karen Johnson: So let's get back to the steering committee in terms of the and we'll just focus on the modified score, the modified score that you've been talking about so we can move on but this is where if there was evidence it would be helpful to see if how this measure is specified in terms of what constitutes a medication reconciliation matches what's been done in the evidence.

But if you all would take a look at those specifications, what your thoughts were about that in terms of how this measure is - by terms of what is - considered medication reconciliation, does that match your thoughts or from the various studies that have been done.

Karen Farris: This is Karen Farris. If I read the numerator it makes sense to me, is that what you want to hear, I mean, is that what you're wanting us to do?

Karen Johnson: Right, the numerator and specifically the numerator details, both of them.

Karen Pace: I think the medical record is, you know, pretty straightforward and then the other ones are codes so I assume that code is saying there was a med rec that happened.

Female: Yes, that's what I...

Karen Pace: There is some code in Table EMRP-A or there's a CPT code, 1111F, and then there are three different ways that you could see it in a medical record that was sampled.

Dawn Alayon: Okay and that coincides with your understanding or how medication reconciliation should be done?

Karen Pace: The ones in the medical record do and I'm just, you know, NCQA I don't think is going to put the wrong code there. I don't know the code for med rec so...

Dawn Alayon: I'm talking about the medical record description.

Karen Pace: Yes, okay, yes. The one in the medical records - this I Karen Farris - makes sense to me.

Karen Johnson: Okay.

Karen Pace: The three instances, you know, it can be one or two or three and I think they're all saying somebody looked at it and documented it in some way.

Karen Johnson: Okay, I hate to do this but our time is really getting by so unless there are some really heavy questions on your mind for this measure, let's go on to the next one and talk about it a little bit. Okay. 0097, we asked Bill Frohna to be our lead discussant on this. Are you there, Bill? Hmm.

Operator: And if you have dialed-in, please press star 1. And we'll open your line, sir. Please go ahead.

Bill Frohna: Yes, I'm here. This is Bill.

Karen Johnson: Thanks, Bill.

Bill Frohna: So yes so I've been asked to take a look at it and review the Measure 0097 submitted by National Committee for Quality Assurance, specifically the second of the two med rec type measures and a brief description, percentage of patients aged 65 years and older discharged from any inpatient facility, hospital skilled with nursing facility or rehab and see within 60 days following discharge in the office by the physician providing ongoing care who had a reconciliation of the discharged medication with the current medication list in the medical record documented.

Numerator, patients who had a reconciliation of the discharged meds with the current medication list in the medical record documented and it defines what the medical record must indicate physician is aware of the inpatient facility discharge meds and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.

The denominator is all patients aged 65 and older discharged from any inpatient facility as previously defined and seen within 60 days following discharge in the office by the physician providing ongoing care.

No exclusions were noted. Process type measure with a data source being similar I think as far as the claims data, electronic health records and electronic sources as well as paper record.

And this comes down to the actual clinician, group practice clinician, individual rather than the health level provider measure previously discussed. It's not paired with any other measure and nor is it included in a composite.

The results that if we go through the summary of the results obtained, basically importance to measure and report, we had two yeses, four nos on the importance to measure. The impact as far as high impact six, moderate zero, low zero, I zero and then the performance gap was high for moderate to no zero or no Ls or no Is on that one.

I think looking at the rationale, the high percentage of medication errors on admission or discharge for a high percentage of patients is what the real rationale is for doing this and again as we've discussed previously there's intuitively I think it makes a lot of sense that there are not comments or not consistent standards for collecting data on disparities.

Distribution of scores showed meaningful variation. Only a small percentage of eligible MDs were sampled. I think that's coming from the PQR information. Less than optimal performance.

Disparities are not a focus of analysis at this time and then getting back specifically to the impact and importance, the person who commented here believes that the measure supports a specific health priority reducing inappropriate medication use and (probably) pharmacy through post-discharge med rec in the provider's office.

I think that probably is a nice summary of it right there. With regards to evidence looking at that, the evidence based on the decision logic summary was yes for two, no four, and basically kind of came to the same discussions we had previously with regards to quantity H1, M3, L2, quality H1, M1, L4 and consistency H1 M2 L3.

And I think it just is that the information out there as far as published studies is relatively low. It's a comment here, the structure process outcome relationship is complex. There's even an accurate current med list that may not be an accurate reflection of what the patient is really taking at home.

Another comment was about the timeframe not being justified and why is it the physicians? Is it a requisite? With regards to quantity, it appears that there are four studies. What is unclear is that there's no real clear body of evidence to support the measure.

The developer draws a correlation to benefit and harm of not doing med rec but again based on limited evidence; however, one could apply professional knowledge and judgment and terminate this as a directed link with reducing medication errors, (probably) pharmacy and overall proved patient outcomes so essentially the same discussions I think as the previous measure.

From the scientific acceptability of the measure properties, reliability, high four, moderate one; validity, high three, moderate one, low one. In summary it came down to five yeses and zero nos. I think a couple of comments there that within 60 days a patient could be hospitalized multiple times and the numerator and the denominator didn't seem consistent.

Other comments, reliability testing is high. I think the expert panel was used to test the validity, multiple specialties were involved, 74% of the respondents who agreed or strongly agreed that the measure could accurately distinguish good and poor quality so I think that was felt that results were fairly good in 2008 and improved over 2007.

And I think they felt that using this, there was one of the comments was that there was much stronger reliability and validity evidence compared to '05 by four so just a previous measure. With regards to usability, overall it was high for two, moderate two, low for one.

There is meaningful understandable and useful information for public reporting and quality reporting and I think one of the other comments had to kind of go back towards rating usability as a medium because of the lack of evidence cited.

The individual wrote that although they have the belief that it's a meaningful and useful measure, the developer can make a stronger case with increased documentation of evidence in citing outcomes of completing/not completing post-discharge med rec.

Looking at the feasibility element, again summary there is high two, moderate two, low zero and one insufficient and basically a comment there is how is the provider going to indicate that they are aware that the information is from a hospital discharge, that the required data elements are generated routinely during follow-up visits and are easily retrievable to the EHR?

The person did not see an error rate or inaccuracies addressed in this submission and finally in that same comment or another comment in that grouping, the measure is reported by PQRS and the number of physicians reporting has increased significantly over past years so a sign of feasibility, still quite low.

Total percent of all physicians which may reflect the burden of data collection for those who participate in PQRS so the preliminary assessment of the criteria met suitable for endorsement and so an even distribution there of yes three and no three.

Some felt that the timeframe is too long to provide a realistic measure with constant patient numbers and discharge numbers. Other felt that those who were willing to support the measure should improve quality when that probably was not felt to support it, not sufficient evidence linked to outcome.

There seemed to be another comment. There seems to be a fairly strong case for the suitability of continuing to report this measure but better conclusion based on evidence about why this is a quality indicator and outcomes of med rec would be helpful to the reviewers.

One additional comment about this came up, had to do with could the timeframe be shortened and specifically it was not clear if this will prevent readmissions or ER visits, also how will the provider indicate that they are aware that med rec is from a hospital discharge and the electronic medical record and have that data captured?

So again I think in comparison, not dissimilar from the prior one, still questions about the evidence to support it. Intuitively it makes some sense and I think some questions about the duration of the measure are in there as well.

Dawn Alayon: So this is the NCQA team. Would you like to respond to some of those issues or would you like to ask specific questions in the interest of time?

Karen Johnson: Let's have the committee discuss. If they have specific questions they can direct them to you so steering committee in terms of the differences in the evidence and the 60 days I guess is the big consideration so you want to discuss that?

Bill Frohna: How can this - I guess one question basically would be - why was 60 days chosen? I think, you know, if you look at most of the initiatives to reduce hospitalization - all-cause rehospitalization - is to set patients up with appointments in a timely manner.

And so now you're looking at, you know, seven days out or somewhere in that timeframe so just kind of wondering why 60 days was picked as the...

Dawn Alayon: So 60 days was - it had been chosen - mostly as a feasibility. This measure given the sample size that we have when you look at outpatient visits within 30 days after readmission. You just don't currently have the sample size in order to accurately measure this at the physician level which, you know, it takes larger sample sizes at the physician level to have an accurate measurement.

So and we agree with you about the importance of having medication reconciliation within 30 days which is why we really see these two measures as fitting together. One, you know, the plan-level measure has the sample size appropriate and can also allow for medication reconciliation to occur in other forms than an outpatient visit.

So if somebody can't get in particularly in rural areas to see their regular provider then this is something that can occur over the phone and we really want to allow for that so as not to penalize providers in that area.

The reason that, you know, part of the reason that this measure has to have that 60 days is because this is really only looking at the denominators, only people who came in for an outpatient visit after hospitalization so you really need to have that sample size in order to measure this.

So together we hoped that they are a good quality indicator and they're going to encourage more medication reconciliation because as you can see, you know, the rates are not as high as you would like them to be.

Kathleen Aller: This is Kathleen. If you really want to use these together and I would certainly concur that we would want to do that, why do they use different age ranges?

Dawn Alayon: That may be because - are you referring to the 66 and above?

Kathleen Aller: One is 65 and older and one is 66 and older.

Dawn Alayon: That has to do with just the way that we specify our measures here at NCQA. The one that's specified for 66 and above has a one-year look-back period meaning that we look at everyone who is 66 and we look one year previously so one year back to when they were 65 so

the age range of the population is actually identical between the two measures. It just has to do with the look-back period.

Karen Johnson: Are there any other questions or concerns you'd like to put the NCQA representatives?

Christine Klotz: This is Chris Klotz and the comment was made earlier about the fact that doing the medic - and this is more an experience-based thing I think - trying to think from the perspective of the patient, the point made that checking the medications based on discharge medications may not be matching what the patient is taking.

And I guess one of the things that I'm just thinking about again is what other thoughts are there with these measures is will they really be able to get to what the individual patients is actually taking?

You know, there's so many reasons why they don't follow their more formal medication lists, you know, they can't get their medications, too expensive, give them side effects, forget, all those things.

Dawn Alayon: Well, this is the NCQA team. We actually have an additional measure that you will be seeing at the steering committee. I think it's going to Workgroup 2 that asks does the medication review where the physician does assess what medications the patient is actually taking, what dosage, whether or not the patient knows why they're taking those medications so I think to get at some of those issues that you are speaking about.

Christine Klotz: Okay.

Karen Johnson: And can you tell us what measure number that is just so everybody's clear on that one?

Dawn Alayon: Measure 0553.

Karen Pace: And this is Karen Pace then I guess related to the prior question, why would you not combine current medications with medication reconciliation and discharge?

Dawn Alayon: So the intent of the measure is slightly different. The medication review is something that happens annually. We ask it for all patients regardless of whether or not they have been hospitalized.

Medication reconciliation is something we require in addition to medication review if someone has been hospitalized during the past year and that's basically to catch-up on any changes that may have been made in the hospital.

Female: Which is known to be a high-risk time.

Female: And then what happens for patients who get - because if we think about the 0554 - they could have had reconciliation within 30 days so as long as they have one reconciliation within the 60 days, it counts so basically this - there will be some people - who will fall into the denominator and the numerator that also would be in 0554.

Dawn Alayon: Yes. There will be, I mean, so these are different measures - they have different accountable units in different patients populations - so one is looking at, you know, a physician's panel of patients and one is looking at the health plan.

So it's feasible that yes, a physician could be within a health plan and so this is being reported twice but the rates are not to be compared with each other I think.

Female: Right, well the CPT code is something different.

Dawn Alayon: The CPT code is the same.

Female: Oh.

Dawn Alayon: The CPT2 code, sorry, for med...

Female: 1111S?

Dawn Alayon: Yes.

Female: Yes, you're right, sorry. My mistake. The other thing NCQA, can you comment on the fact that although this has been reported in CQRS that in terms of the feasibility, you know, it's still a very small number of physicians who choose to report that measure. Do you have any insight as to why and also maybe some comparison with other measures where there's more reporting?

Dawn Alayon: I believe we might have someone from AMA PCPI if they want to comment on that. Is someone on the line? I believe you have to press star 1 to be able to speak.

Operator: That's correct. If you would like your line open, press star 1 if you've dialed-in on a participant line.

Katherine Ast: We've dialed-in on the private agenda. Can you hear us?

Female: Yes.

Operator: Yes.

Katherine Ast: Okay, hi. It's Katherine Ast with Mark Antman and Sam Tierney. Could you please - and Audrey Dickerson - could you please repeat the question?

Female: Yes, my question was about the feasibility assessment and the fact that the number of physicians that are reporting this measure is still low and not increasing a lot although it is increasing.

And I was just wondering if you have any other data or insights as to why the reporting is low because it could indicate a feasibility issue and also maybe you have some comparative information about other measures that are reported more frequently so we could assess the feasibility based on that type of information.

Katherine Ast: I just want to ask if Joanne Cuny's on the line? Okay, that was our testing staff. She might have had to go off to another meeting.

Operator: She is online and has an open line.

Joanne Cuny: Sorry, I was...

Operator: You may want to check your mute button, go ahead.

Joanne Cuny: I just unmuted. Actually I don't have in our feasibility assessment data the type of information that I think that you're asking for right now and in terms of why do we think that physicians are not choosing to report on this measure.

I'm not sure that our data would reflect that but I am wondering if it has to do with the discussion that was previously part of other issues around these measures in terms of the 60 days or which

physician the physician is seeing within that timeframe after leaving the hospital so I don't think that our data will tell you why physicians might not choose to report on this measure.

Did I understand the question?

Female: Yes, or even statistics on other measures that are reported that where you have - so we can - compare and contrast the number of physicians to report to the measures, this is not other which could be, you know, which could be an index of feasibility of reporting.

Joanne Cuny: I'm sorry, I really don't have - I don't have other data - in front of me so I'm afraid I'm not prepared to answer that question.

Female: Well, thank you.

Lauralei Dorian: Okay, well it sounds like we've had some really good discussion on these team measures and because it is almost 2:45 and we need to make sure that the public has an opportunity to make some comments, I will ask if there is any more burning issues that we really have to address right now and if not, then we'll open the lines to the public.

Okay, operator, can you go ahead and open the public lines if anyone has any questions or comments from the public?

Operator: And press star 1. Again press star 1 if you'd like to have your line opened. And no one has signaled.

Lauralei Dorian: Okay. We have a couple of more minutes left in our timeframe here so are there any other questions about any of these four measures that anybody wants to address before we head off to talk about our upcoming next steps?

Female: I have a general question with these two that we have three yes and three for, what are we recommending to the whole group of is that fine that we have it that way and then when it comes before the whole group, we hope to break the tie?

Kathleen Aller: This is Kathleen Aller. I because of a family crisis last week was not able to enter mine so I don't know whether I'll be a tiebreaker.

Female: So I guess you will be one way or the other.

Kathleen Aller: But I may be as I comment on some of these.

Lauralei Dorian: I think, well let me try to answer your question first. Now that you've had a chance to talk to the developers, some of you may want to change how you initially evaluated the measure so you can certainly do that.

You can go back into the tool and re-enter and we will re-aggregate so that what you have in the in-person meeting will be the most current thinking of everybody on the workgroup so you definitely have time to do that.

And if it still turns out that it's a tie then it'll just open up some more discussion points that may come up in the in-person meeting. Does that help? Does that answer?

Female: Yes, thank you.

Karen Pace: And this is Karen Pace. I mean, we have a few more minutes. Are there key things that you all wanted to discuss in terms of your yes or (no) vote on the measures? Okay.

Lauralei Dorian: Okay, well if nobody has any other questions that you really want to ask right now, I do want to just remind you again that we have the SharePoint discussion forum and you can certainly go in there and post questions to your fellow steering committee members and use that as an opportunity to continue this discussion.

So and I also want to remind you that we ask you to look very deeply at these measures that for the in-person meeting we are hoping that you will all have a chance to look at all of the measures and be able to comment on all of the measures even if you don't put in an official evaluation for all of them through the online tool.

So with that said, I'm going to hand it back to Lauralei who's going to talk a little bit about some upcoming steps that we have.

Lauralei Dorian: Yes, thanks everybody for your participation today and thanks to the lead discussants and the developers that are calling-in as well. We also wanted to remind you that we do have two more workgroup calls coming up, one later today and one tomorrow so you are welcome to call into the conference calls either just to listen or participate and you're welcome to submit ratings for other measures that weren't part of this call as well.

So we will be working on compiling summaries of these calls and sending them out to everybody and then we do have our in-person meeting at the end of February. It's a two-day meeting so we have two full days.

As you know we didn't get any new measures submitted to this project so we at NQF have been talking with the co-chairs about how to sort of best capitalize on that extra time that we have. We were talking about the 25 preferred practices that were endorsed in 2010 and how they could be used because a lot of work and effort went into developing them.

And so we were thinking about having a sort of exercise that will be held by (Nicole McKelvan) who was involved in that work back in 2010 and has done something somewhere with cultural ((inaudible)) preferred practices so just to alert you to that because you will be receiving an e-mail from her soon with some instructions on some prework that they used to do around that (for our interest) the meeting.

Karen Johnson: No, I don't think so. I think that does it.

Lauralei Dorian: Does anyone have any other questions before we end the call?

Female: I have just the one quick question about reevaluating our scores to some of the measures. One way is just to wait till the full discussion of the committee and do that at that time versus doing it now or I don't know what you recommend?

Karen Johnson: Well, if you go ahead and do it now or after the call, then we will re-aggregate everything and provide another set of tallies so that you would have that to discuss at the in-person meeting.

But at the in-person meeting, you will actually be giving your final evaluation there as well so you will be giving an evaluation in the in-person meeting and it's up to you whether you want to give another basic preliminary evaluation given the answers that you've heard on this call. Does that make sense?

Female: Yes, thank you.

Karen Johnson: Okay.

Lauralei Dorian: Is there any other questions about the process moving forward or the next steps? Okay. At this time (necessarily) which is great, thanks again for your participation and we look forward to

either hearing from you again on the other conference call or seeing you in person in a few weeks. Thank you.

Female: Thank you.

Female: Thank you.

Female: Bye.

Female: Bye.

Male: Bye.

END