NATIONAL QUALITY FORUM

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COMPOSITE MEASURE EVALUATION
GUIDANCE PROJECT

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TECHNICAL EXPERT PANEL MEETING

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FRIDAY
NOVEMBER 2, 2012

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The Expert Panel met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Elizabeth DeLong and Patrick Romano, Co-Chairs, presiding.

PRESENT:

ELIZABETH R. DELONG, PhD, Duke University Medical Center
PATRICK ROMANO, MD, MPH, UC Davis School of Medicine
JOHN D. BIRKMEYER, MD, University of Michigan
DALE BRATZLER, DO, MPH, Oklahoma University Health Services Center*
JAMES CHASE, DO, MPH, Minnesota Community Measurement
NANCY DUNTON, PhD, FAAN, University of Kansas Medical Center, School of Nursing
ELIZABETH GOLDSTEIN, PhD, Centers for Medicare and Medicaid Services
SHERRIE KAPLAN, PhD, MPH, The University of California - Irvine
LYN PAGET, MPH, Health Policy Partners
DAVID SHAHIAN, MD, Massachusetts General Hospital

STEVEN WRIGHT, PhD, Veterans Health
  Administration

ALAN ZASLAVSKY, PhD, Harvard Medical School

NQF STAFF:

HELEN BURSTIN, MD, MPH

KAREN JOHNSON, MS

ELISA MUNTHALI, MPH

* Participating by teleconference

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

2 (8:34 a.m.)

3 MS. MUNTHALI: Hello and good

4 morning everyone. Welcome to the Composite

5 Measure Evaluation Guidance in-person meeting.

6 My name is Elisa Munthali and I am a Senior

7 Project Manager with NQF.

8 Before I turn the meeting over to

9 the technical panels' co-chairs, there are a

10 couple of housekeeping items I just wanted to

11 bring to everybody's attention.

12 I wanted to remind everyone that

13 today's meeting is being recorded and

14 transcribed. And so we ask that when you are

15 speaking, you turn on your microphone and

16 speak into the mike, so that we can capture

17 your comments.

18 And for everyone that is in the

19 room today, your received a packet of

20 handouts. I ask that you keep those handy.

21 We will be referring to those and we will let

22 you know which documents we are speaking

1 about. And also for everyone in the room, we
2 just wanted to let you know where the
3 restrooms are. They are just beyond the
4 elevator right by the reception area there and
5 through the glass doors. And also just to
6 remind you that we have breakfast in the back.
7 So please help yourself throughout the morning
8 today.
9 So I will turn it over to Helen
10 Burstin who will continue with our welcome and
11 conduct our disclosures of interests.
12 DR. BURSTIN: Great. Hi,
13 everybody. Helen Burstin. I think I know
14 everybody. I am the Senior VP for Performance
15 Measures at NQF. We will go around and do
16 introductions and disclosures at the same time
17 -- there she is. Excellent planning.
18 Before I do that, why don't I ask
19 Liz and Patrick to introduce themselves?
20 DR. DE LONG: I'm Liz DeLong. I'm
21 the Department Chair of the Department of
22 Biostatistics and Bioinformatics at Duke

1 University. And I have been at Duke for years
2 and years and I have worked with Dave Shahian
3 and Patrick but I have heard the rest of your
4 names and I think you are probably all much
5 better at composite measures than I am at this
6 point but we will see.
7 DR. ROMANO: Hi. And I am Patrick
8 Romano. I know most of you. I am a general
9 internist and oral pediatrician based at UC
10 Davis Health System in Sacramento, California
11 and long-time health services researcher
12 involved in Quality Measurement. I worked
13 with NQF before on several previous projects,
14 as well as with AHRQ and other organizations
15 in the field. We will talk a bit more, I
16 guess we will have disclosures again and I
17 will make separate disclosures.
18 Anyway, it is a pleasure to be
19 here and thanks to NQF for convening us for
20 this purpose.
21 DR. BURSTIN: Great. Well thanks
22 again. So what I would like you to do is as

1 we go around the room if you could introduce
2 yourselves. You may remember you filled out
3 a disclosure of interest form which you sent
4 to us. You don't need to fully go through all
5 of that. I think the key thing at this point,
6 since we are not really evaluating measures
7 today so you can't have any conflicts with
8 specifics measures, is really just I think
9 more than anything else to give a sense of
10 sort of where you are coming from for your
11 fellow committee members. And if there is any
12 areas that you think are important for people
13 to understand in terms of potential bias,
14 everybody has got opinions, obviously, we all
15 are here today because we have opinions and do
16 research and feel strongly about things.
17 So as you are going around the
18 room, introduce yourself, where you are from.
19 If you think there is anything relevant that
20 your co-committee members would want to hear
21 about, feel free to mention that. I also
22 welcome Karen Johnson, our Senior Director who

1 made it off a very late train from Maryland.
2 So thanks.
3 Start with you, Steve?
4 DR. WRIGHT: Hi, everyone. I'm
5 Steve Wright. I'm with the VA Department of
6 Veterans Affairs, Director of Epidemiology
7 currently acting as the Director of the Office
8 of Performance Measurement. I have been
9 involved in measurement for many years, health
10 services researcher as a background.
11 I don't have any particular
12 biases, other than rah, rah, VA!
13 (Laughter.)
14 DR. ZASLAVSKY: I'm Alan
15 Zaslavsky. I am a Professor of Health Care
16 Policy Statistics, there is a parenthesis
17 there, at Harvard Medical School, Department
18 of Healthcare Policy. As my title suggests,
19 I'm a statistician. I have done a lot of work
20 particularly on the CAHPS survey since the
21 inception of that project and also with the
22 HEDIS measures.

1 DR. CHASE: Good morning. My name
2 is Jim Chase. I am President with Minnesota
3 Community Measurement. We are an organization
4 that does quality measurement around the state
5 of Minnesota and have about 600 medical sites
6 of care that report data to us just about
7 every provider in Minnesota.
8 And we use composite measures. We
9 have a couple that are endorsed by NQF so that
10 would be my probably major bias and this is
11 just the experience in using the all-or-none
12 composites in our community.
13 MS. PAGET: Good morning, my name
14 is Lyn Paget. I'm down from Boston where I
15 have recently started some work with a group
16 called Health Policy Partners and Independent
17 Collaboration of Patient Policy Experts. I
18 spent many years at the Informed Medical
19 Decisions Foundation. So I am here much less
20 as a measurement expert but more so in the
21 position representing the patients and
22 consumers whom we hope will benefit from these

1 measures.

2 DR. DUNTON: Good morning. I'm

3 Nancy Dunton. I'm a research professor at the

4 School of Nursing at the University of Kansas

5 Medical Center where I direct the National

6 Database on Nursing Quality Indicators. We

7 collect data quarterly from 1900 hospitals

8 across the U.S. on structure, process, and

9 outcome measures relating to nursing care and

10 we think about composites.

11 DR. GOLDSTEIN: Liz Goldstein.

12 I'm Director of the Division of Consumer

13 Assessment and Plan Performance at CMS. I

14 have been involved in the CAHPS surveys for

15 many, many, many years. My division is

16 responsible for most of the CAHPS surveys that

17 CMS implements as well as we are starting to

18 develop three new patient experience surveys.

19 They are just starting up.

20 My division is also responsible

21 for the star rating system for Medicare

22 Advantage. So we use lots of different

1 measures for that, as well as we create our
2 own composites for value-based purchasing for
3 Medicare Advantage.
4 DR. KAPLAN: I'm Sherrie Kaplan.
5 I'm a psychometrician by training. I'm
6 Assistant Vice Chancellor for Healthcare
7 Measurement and Evaluation at UC Irvine. And
8 I have been working in creating composite
9 measures most distantly at Rand with a medical
10 outcomes study. Most recently with the State
11 of California, I am trying to help advise them
12 how to sample, whether to sample more items
13 per constructs, more patients per doctor, more
14 doctors per clinic, more clinics per
15 institution, et cetera, et cetera, and making
16 the most out of how we look at these
17 composites to do institutional performance
18 assessment.
19 DR. BIRKMEYER: Good morning.
20 John Birkmeyer, I am a researcher from the
21 University of Michigan. I direct the Center
22 for Healthcare Outcomes and Policy there and

1 as a researcher I have been engaged for many
2 years with colleagues, economists, Doug
3 Staiger at Dartmouth and Justin Dimick from
4 University of Michigan with more
5 statistically-based types of composite
6 measures looking mainly but not totally at
7 surgical care.
8 I have been involved with the
9 Leapfrog Group for many years and have been
10 involved with implementations of its composite
11 measures. Most recently with Patrick, the
12 hospital-wide summary composite score for
13 patient safety and earlier for more
14 statistically-based composite measures for
15 surgical standards.
16 By way of disclosure, I am the
17 founder and Chief Scientific Officer of a
18 company called ArborMetrix that is not a
19 developer of measures but we do implement
20 performance measurement systems for insurers,
21 health systems and for professional
22 organizations.

1 DR. SHAHIAN: Hi, I'm Dave
2 Shahian. I'm at Mass General and Harvard
3 Medical School. I chair the STS National
4 Database and its Quality Measurement Task
5 Force. I have been involved in development of
6 two cardiac surgery composites, one of which
7 is NQF-endorsed and publicly reported for CABG
8 and another one for isolated AVR, which is
9 just, it is going to be published in the peer
10 review literature next month and will also be
11 publicly reported and submitted to NQF.
12 I have no disclosures. My
13 positions with STS are uncompensated.
14 DR. ROMANO: Okay and just to
15 amplify a little bit, obviously I am an
16 employee of UC Davis Health System but I also
17 have done fairly extensive work as a
18 subcontractor to Battelle Memorial Institute
19 working on the AHRQ Quality Indicators
20 program. So in that capacity, I have been
21 involved in some development testing and
22 application of the AHRQ QI composites, three

1 of which are currently NQF-endorsed. I have
2 also, as John mentioned, been a member of Leap
3 Frog's expert panel related to its hospital
4 safety score composite program. I have also
5 advised the California Office of the Patient
6 Advocate, which is responsible for health plan
7 and medical group reporting in California
8 related to construction and reporting of
9 measures, including a compositing of measures.
10 And I have also done a little bit
11 of work on expert panels for a variety of
12 organizations, including CMS, as well as the
13 AHRQ and probably others -- Joint Commission
14 and probably others I'm not thinking of.
15 In any case, Liz?
16 DR. DE LONG: I worked with Dave
17 on the composite measure for the STS CABG
18 surgery and I have primarily focused on
19 outcomes research and have no ties with
20 industry or other developers.
21 DR. BURSTIN: Dale are you still
22 with us on the telephone? Can you introduce

1 yourself?

2 DR. BRATZLER: I am. I am, thank

3 you.

4 DR. BURSTIN: Yup.

5 DR. BRATZLER: My name is Dale

6 Bratzler. I am a professor in the Department

7 of Health Administration and Policy in the

8 College of Public Health at the University of

9 Oklahoma and also a Professor in the College

10 of Medicine.

11 I have worked on the development

12 of performance measures for many years,

13 primarily as a contractor to the Medicare

14 program. Currently I do have contracts that

15 are through the College of Public Health to

16 support continued measure maintenance for the

17 Medicare Program. I also have a contract to

18 support external quality review activities for

19 the State Medicaid program.

20 My work in composite measures has

21 really been relatively limited. We have

22 developed composite measures that we have used

1 over the years, primarily to support
2 performance improvement. We really have not
3 developed composite measures that we have ever
4 recommended for formal endorsement or public
5 accountability. So we have been using
6 composites for some time but primarily we have
7 been using them to help drive performance
8 improvement.
9 DR. BURSTIN: Thanks, Dale. Does
10 anybody have any concerns about anything they
11 have heard about each other? Any further
12 questions or probing or are we ready to go to
13 work?
14 All right, great! Thank you
15 everybody. I guess at this point, you are
16 five minutes ahead of schedule, Karen. This
17 is Karen Johnson, who is our Senior Director
18 on this project. Karen Pace, who many of you
19 was hoping to be with us today but
20 unfortunately has a personal urgent issue and
21 can't be with us. But Karen is well primed
22 and ready to go.

1 MS. JOHNSON: So thank you. And I
2 am sorry I am running late today so I haven't
3 got to meet you guys but I am really honored
4 to get to work with you. Composites are new
5 to me so I get to learn from some of the best.
6 So I am really excited about this.
7 So we wanted to give you just a
8 little bit of overview and context about NQF's
9 experience with composite measures. And just
10 to remind you, in 2008 and 2009 NQF convened
11 a TEP to identify a framework for evaluating
12 composite measures and during that project, a
13 definition was created or developed and
14 principles were articulated in terms of how to
15 evaluate composite measures. And also
16 specific criteria were developed so that we
17 could evaluate measures as they came in. And
18 at that time four AHRQ measures were evaluated
19 and kind of served as a dry run for our
20 framework and evaluation criteria.
21 So since that time, however, we
22 have updated both our criteria and our

1 guidance for our other criteria that we use to
2 evaluate measures, specifically our evidence
3 and our scientific acceptability, reliability
4 validity guidance has been updated.
5 So what we need to do with this
6 project is pretty much re-think our guidance
7 for composite measure and evaluation and make
8 sure that it fits with our updated guidance
9 that we have for our regular measures.
10 So with that in mind our goal is
11 to update our guidance. So the three things
12 that we would like to accomplish with today's
13 meeting or to identify appropriate evaluation
14 methods for various types of composite
15 measures, identify unique considerations for
16 evaluating composite performance measures in
17 relation to our endorsement criteria and then
18 finally develop guidance for evaluating and
19 submitting composite measures for endorsement.
20 So the actual nuts and bolts of what our
21 submission forms look like.
22 So you have some resource that we

1 have tried to provide for you. And Elisa
2 thank you for getting all this printed out in
3 my absence this morning. Beyond your
4 expertise, which I know you have bucket loads
5 of, we have provided you an agenda so you know
6 where we are going today. The briefing memo
7 that Karen wrote, which I think we will
8 probably follow that a lot as we go through
9 our agenda for our meeting.
10 We have provided you our measure
11 evaluation criteria so that you know what we
12 are trying to align with. We have also given
13 you our composite criteria so you know what we
14 currently have now and we have also given you
15 kind of a not very pretty but I think it
16 covers the basics of our composite submission
17 form so that you can see the actual questions
18 that we asked developers to fill out when they
19 submit a composite measure.
20 Just a little bit more context
21 beyond what I have already mentioned. All
22 NQF-endorsed measures are considered suitable

1 for both performance improvement and for
2 accountability. So currently we do not
3 endorse performance measures for specific
4 accountability applications. And then also
5 the term composite measure and even the term
6 composite means many things to many people but
7 it can refer to scales, or instruments to
8 assess individuals or performance measures
9 used to assess providers. So just a reminder
10 that we endorse the performance measures, not
11 the instruments or scales.
12 Okay, so on to our experience.
13 Yes?
14 DR. DE LONG: Can you go back?
15 I'm not sure I understand what you mean by NQF
16 does not currently endorse performance
17 measures for specific accountability
18 applications.
19 DR. BURSTIN: So essentially when
20 a measure is endorsed by NQF, at least at this
21 point in time, the assumption is it is ready
22 to go for any purpose. If somebody picks it

1 up for payment, if somebody picks it up for
2 public reporting, that is the assumption out
3 the gate. What we don't do is distinguish
4 this measure is great for QI but it is not
5 quite ready for payment. And it has been an
6 issue that keeps coming up in a big way, as
7 Sherrie knows well from our All-Cause
8 Hospital-wide Readmission Project.
9 And it may be something that will
10 morph over time. Currently there is another
11 partnership called the Measures Application
12 Partnership that actually helps to think
13 through specifically which applications are
14 appropriate for which measures and which
15 federal programs. But it is an important
16 distinction just because people often times
17 say this measure is great for this purpose but
18 I wouldn't use it for that. And at least at
19 this point in time, that is not the way we can
20 really kind of separate out that thinking.
21 DR. BIRKMEYER: So just to be
22 clear though because this is so crucial and

1 more crucial to the composite measures than
2 any other type of performance indicator, the
3 measures need to meet some low bar that it
4 could be used either for improvement purposes
5 or for accountability or steerage but
6 recognizing that obviously some measures are
7 going to be much better suited for one or the
8 other. Is that fair?
9 DR. BURSTIN: That's fair, yes.
10 DR. ROMANO: Well yes, I guess
11 maybe you could elaborate on this a little bit
12 more but the fact that there is a measure
13 applications partnership that is trying to
14 think systematically about the application of
15 largely NQF-endorsed measures in various
16 accountability applications implies that the
17 existing NQF process doesn't really
18 comprehensively consider the implications of
19 different accountability or specific
20 accountability applications.
21 DR. BURSTIN: Right. So there is
22 an assumption that if it has been endorsed by

1 an NQF committee, endorsement side committee,
2 that they are primarily focused on the
3 measurement properties. They are really
4 looking at the criteria that we use to assess
5 the measure. They are not looking to say, for
6 example, this measure would be more
7 appropriate, to put it in real terms, this
8 measure would be great for the hospital public
9 reporting program but we don't think it is
10 ready for value-based purchasing. That is not
11 something we do as part of the endorsement
12 process. That is currently something done as
13 part of the MAP process.
14 Again, I think we are increasingly
15 -- it is an interesting time, as all of you
16 know, in a big way. And if you look to the
17 example of Massachusetts, for example, they
18 did come up with some criteria of what our
19 higher stakes measurement criteria might be.
20 It is not something we have explored yet but
21 it is certainly something, it is hard to deny
22 a sort of back of mind of seeing for example,

1 the MAP last year put one composite as being
2 okay for the hospital public -- you know for
3 the IQR, hospital public reporting and yet
4 said it was not okay for value-based
5 purchasing. That implies a difference that
6 people are sort of thinking through. I don't
7 know that we have teased exactly what it is
8 that the MAP is using to make that decision,
9 other than the multi-stakeholders kind of
10 talking it through. But I think it is an
11 important issue and you are absolutely right,
12 John because obviously composites are pretty
13 high stakes. And you put it all together and
14 you say this is safety or this is high quality
15 for diabetes. It does have potentially a
16 different lens. And they do tend to be picked
17 up for, I would argue, sometimes higher stakes
18 applications than I think some of the other
19 more individual process measures might be.
20 MS. PAGET: So Helen, can I just
21 ask then do you think it would be part of the
22 role of this group today to make any

1 recommendations about that or do you think
2 that that is in the MAP domain and we don't
3 need to go there? Because I find myself
4 looking at this and thinking about the
5 influence of these measures just on cultural
6 change and the care experience, which is
7 really a completely -- and as I read through
8 that one paper from the Research and Battelle,
9 it was that one example of just using these to
10 choose a physician, well that is just the tip
11 of the iceberg in my mind. That is really
12 probably not the way these are ultimately
13 going to be used.
14 So for clarification, I just
15 wanted to know whether you think is something
16 we are going to discuss today or not.
17 DR. BURSTIN: You know you are
18 really smart people sitting around a room. I
19 think anything is fair game. At the end of
20 the day, we want to make sure we accomplish
21 the goals of saying what do we do when these
22 measures come forward to us because we have

1 seen every stripe of composites come to us and
2 at times we feel like we are really pounding
3 a square peg into a round hole. So anything
4 you guys could help us think through with
5 clarity that we really do have an approach
6 that makes sense. If you have other thoughts
7 about these other issues, again, we would be
8 open to hearing about it, as long as we get
9 the rest of the work done because I honestly
10 don't know what will come forward. I think
11 there is just going to be a lot more movement
12 in the next couple of years of just clearly
13 seeing a sense of high-stakes measurement
14 versus not in understanding how to handle
15 those.
16 But at this point in time for
17 where we sit at this point, we should assume
18 that anything that is endorsed by NQF if
19 appropriate for any of those applications.
20 MS. PAGET: It does work for me
21 but I actually had another question on this
22 side which came up with the notes on the

1 composite measures that have been submitted
2 and I think it was in reference to CAHPS where
3 the statement is made that NQF doesn't look at
4 the survey instrument itself. I just need to
5 understand.
6 DR. BURSTIN: It's not that we
7 don't look at the survey instrument itself.
8 Obviously, Liz and Alan and others can help
9 here but essentially at the end of the day
10 what we are endorsing is the performance
11 measure based on use of the survey. So we are
12 not endorsing the CAHPS tool, per se. We are
13 endorsing a performance measure based on
14 CAHPS.
15 So this is a big issue it says at
16 the bottom of that slide there "see PRO
17 project." Some of you may know we have been
18 doing extensive work over the last six months
19 or so on a project around patient-reported
20 outcomes and really trying to tease this out.
21 So actually as part of that
22 project, we would be happy to show those

1 commission papers with you. It is a very
2 clear distinction between the PRO, the
3 patient-reported outcome as the tool, and then
4 ultimately how do you use the tool in the
5 context of moving to a performance measure
6 using the tool and actually tried to come up
7 with the critical path of how to get there.
8 MS. JOHNSON: Okay, so from 2007
9 until now we have had 28 measures that have
10 been submitted to us that have been flagged as
11 composites. And just to put that into a
12 little bit of perspective, since 2010 we have
13 evaluated more than 400 measures, so 28 out of
14 400, it is a small number but they are
15 difficult because they are complex and that
16 means that some of us working on the projects
17 maybe have never seen a composite come
18 through. So even getting clarity about these
19 criteria is going to be important to us as
20 staff as well as developers.
21 So of the 28 that have been
22 submitted, 22 are still currently endorsed.

1 And you see the breakdowns there. We have
2 three that are all-or-none measures, six based
3 on CAHPS surveys, five on other types of
4 surveys or instruments, and then the remaining
5 eight are combinations of this, that, and the
6 next.
7 So of the 22, some of those have
8 been through endorsement maintenance but not
9 all of them. And I think one of questions
10 that Liz had was in terms of are they useful.
11 At the end of the day, have they been able to
12 improve quality? And we would love to be able
13 to answer that question systematically. Right
14 now we can't just from looking at our data.
15 We do have institutional memory in terms of
16 Helen and Heidi and different folks who
17 sometimes can chime in on these kind of
18 things. But right now, other than if you have
19 some examples that you might want to mention,
20 Helen.
21 DR. BURSTIN: Right. So two
22 things. So the first is that we recently

1 updated one of our four criteria of un-
2 usability, which is now usability in use. And
3 the idea there was to really much more
4 carefully delineate what do we mean by when a
5 measure is useable. And it is really implying
6 that there is significant benefit in terms of
7 driving quality improvement, improvement in
8 performance results, but also not forgetting
9 about potential negative consequences of
10 measurement as being now woven into that very
11 clearly.
12 So as part of that, and that is
13 now coming forward for all measures being
14 submitted, new in maintenance to NQF, a very
15 clear requirement to say of your data how has
16 it helped? Has it moved the needle? Has it
17 potentially hurt as part of that process? But
18 to date, much of what we have gotten from
19 folks has been, here is the measure. It is
20 used in four states. Here is the measure, 16
21 other groups are using it. We don't often get
22 and here is how it moved the needle, actually

1 with the possible exception I would say, Jim,
2 of some of what we have seen from Minnesota
3 Community Measurement when the cardiovascular
4 committee re-endorsed the optimal vascular
5 care composite, Minnesota was able to give
6 pretty strong data showing significant
7 improvements in cardiovascular outcomes in a
8 way that we don't tend to have. But they are
9 above average in Minnesota.
10 But that is the kind of
11 information we would love to be able to get
12 more systematically. So as you are going
13 through this review today, helping us think
14 through in particular about the composite
15 issues, and one of the things we have often
16 heard a lot and it comes up from our consumer
17 purchaser council in particular is if a
18 composite is put forward and is publicly
19 reported, is it also unpacked? So is it
20 unpacked for those obviously trying to improve
21 care in terms of being able to see the
22 individual results but is it also unpacked for

1 the public to see? And I know this is an
2 issue, David, we have talked about with some
3 of the CABG work, for example.
4 But it is just something for us to
5 think about because it does come up.
6 MS. JOHNSON: Okay, so -- oh.
7 Yes?
8 DR. WRIGHT: Just another
9 contextual question. Is there any connection
10 between our discussion and thinking about
11 composite measures in terms of where the data
12 comes from, i.e., electronic measures,
13 meaningful use, that whole connection?
14 DR. BURSTIN: Yes, so we work
15 really closely with the Office of National
16 Coordinator. I am actually on Quality
17 Measures Workgroup as well. So this has been
18 an issue that has come up. I have not seen
19 any composites come forward as part of that.
20 I think it has been pretty hard to get the
21 basic measures put forward. And I think it
22 will be interesting to see how that comes

1 forward. I have not seen any work yet that
2 moves towards composites.
3 But one of the things that keeps
4 coming up, which is interesting, is some of
5 you may have seen that as our criteria have
6 gotten tougher on evidence and testing, in
7 particular, a lot of the measures that were
8 endorsed in the last five years or so are
9 actually not making it through maintenance.
10 And one of the concerns oftentimes
11 is it is a process measure. It is far too
12 distal from the outcome measure. On its own,
13 it doesn't work. But there has been, I think,
14 some interest in saying can you potentially
15 move towards an all-or-none approach of saying
16 if these are all the right process steps that
17 should happen, can those move to be composited
18 into something that becomes more of an all-or-
19 none? I don't think we have a sense of how
20 that is going to play out in an electronic
21 environment yet.
22 DR. ZASLAVSKY: Why would it be an

1 all-or-none? Why would the composite have to
2 be all-or-none for something like that, as
3 opposed to any of the other methods?
4 DR. BURSTIN: You are going to get
5 into this in a big way. For some of these
6 examples, some of the individual process
7 measures are at such high levels of
8 performance, that otherwise there is no
9 discrimination has been one of the concerns.
10 And it may not be that that is the right
11 approach. Maybe it is just time to just look
12 at the outcome and skip the process measures
13 completely but that has been one of the
14 concerns.
15 MS. JOHNSON: Okay, so back to our
16 issues. And I think we have articulated most
17 of the things that are going to come up on
18 these slides but one is distinguishing between
19 instrument-level composites versus performance
20 measure composites. So we have already talked
21 about that in terms of the CAHPS measures.
22 The measures that have come

1 through have been inconsistent in terms of
2 implementation of guidance and forms, both
3 again on staff side and committees that have
4 to evaluate these measures. And of course
5 developers who submit measures.
6 All-or-none measures just don't
7 seem to fit the additional analyses that we
8 have indicated is necessary for composite
9 measures.
10 Sometimes developers either don't
11 identify their measures in composites.
12 Sometimes they do and they are really not.
13 Sometimes they just don't want to use our
14 composite form. So in that case they wouldn't
15 be answering the questions that we ask in
16 terms of evaluating composites.
17 And also the thing that has been
18 problematic at least internally is our
19 composite form has only recently been
20 implemented for online submission. So back in
21 the 2008-9 project we came up with the
22 criteria and then various submission forms

1 have been created but it has only been
2 recently that has been kind of put out so we
3 can grab data and store it electronically.
4 So that is part of the reason and
5 I can't tell you specifically how many have
6 gone through maintenance. I just don't know
7 without out having to go back to our paper
8 records. So a little embarrassing there.
9 We also have had difficulty
10 applying the requirement and all of these kind
11 of merge together some of these issues. The
12 requirement that individual component
13 performance measures be NQF-endorsed or meet
14 all criteria. So what does that really mean
15 and how we apply that to all-or-none measures
16 is one of the questions that we have.
17 Part of our guidance right now for
18 composite measures is that it is pretty easy
19 in a way if the components are NQF-endorsed
20 but I will read you from the previous guidance
21 document. "A component measure might not be
22 important enough in its own right as an

1 individual measure but it could be determined
2 to be an important component of a composite."
3 So what does that really mean?
4 Some folks have interpreted that as not
5 needing to meet our importance criteria, which
6 includes impact evidence and performance gap.
7 So that is our language right now but it is a
8 little unclear what that means, unclear for
9 all of us all the way around.
10 DR. DE LONG: I have trouble
11 envisioning an actual example.
12 DR. BURSTIN: Go to the next
13 slide.
14 DR. DE LONG: Oh!
15 DR. BURSTIN: So did I, so I added
16 the next slide. So you are in good company.
17 MS. JOHNSON: Yes, so Helen will
18 be helping us out on examples here.
19 And then finally on this slide,
20 evaluation of the components themselves are
21 challenging. And you know, you would think
22 that would almost be an easy part of it,

1 easier than the scoring but sometimes the
2 components are not endorsed as stand-alone
3 measures. Sometimes they are competing with
4 other endorsed measures and sometimes they are
5 not harmonized to other endorsed stand-alone
6 measures.
7 So with that, let's go to some
8 examples and let Helen --
9 DR. BURSTIN: Sure. So I just
10 pulled up three examples that I thought might
11 express some of the issues we have had with
12 components. And these are not necessarily a
13 systematic review but the ones that really
14 jump to mind for me, at least, in terms of the
15 ones where we have had issues. So the first
16 one is a measure that was put forward and
17 endorsed by CMS, which was a 30-day post-
18 hospital discharge care transition composite.
19 It was actually a measure of three components,
20 the first was a previously endorsed 30-day
21 readmission. This was done for each of the
22 conditions of CHF, heart failure, are the two

1 we got and pneumonia. That was already
2 endorsed. They then included an emergency
3 department visit and an E&M visit, a follow-up
4 physician visit. They assigned scoring so
5 that it was minus four points for the
6 readmission, minus two points for the ED visit
7 and plus one for the E&M. And at the time
8 this measure came forward, that was a logical
9 sort of compilation of thinking through what
10 a transition composite might look like. There
11 was some concerns about the waiting which were
12 really done, expert panel seemed logical,
13 readmissions are worse than ED visits but
14 again.
15 But the biggest issue was the
16 concern that it wasn't clear that the ED visit
17 itself really did capture a lot of the
18 exclusion of understanding the severity of the
19 ED visit. Was it appropriate/inappropriate?
20 And then concerns raised about the
21 E&M visit component, which was that it
22 completely excluded, for example, home visits

1 by nurses. There is no E&M code. It may be
2 perfectly appropriate transition follow-up
3 care. At the end of the day, though, the
4 thought was composite itself was a really rich
5 conceptual concept and it was reasonable to go
6 forward but we did not, the committee did not
7 endorse the ED visit and E&M visit components
8 and we indicated back to CMS those are
9 important. We would love to see measure that
10 actually appropriately capture follow-up
11 visits and ED visits but these probably
12 weren't ready for prime time as a stand-alone.
13 But we thought as part of the composite they
14 made sense.
15 Now I will tell you when that
16 measure got to the Measures Application
17 Partnership, there was a great deal of concern
18 about how could you possibly have a composite
19 that has components within it that were not
20 endorsed or you didn't think were appropriate
21 for endorsement. So to me that was one
22 example of the kind of issues you have

1 encountered.

2 Did you have a question?

3 DR. DE LONG: I have a comment

4 more than a question. I have heard a lot of

5 buzz about the 30-day readmission measure and

6 I don't know if it is appropriate to talk

7 about that today. This is just an example but

8 I have heard of vignettes were patients were

9 sort of pushed off or potentially pushed off

10 and not readmitted so that they wouldn't count

11 against the 30-day readmission. So that is a

12 potential downside of some of these things

13 that we are discussing.

14 DR. BURSTIN: All are not specific

15 to composites. And certainly Sherrie knows

16 this well, she chaired the committee.

17 DR. KAPLAN: I'm getting a little

18 bit lost in the purpose of kind of the

19 exercise here. If for me, from a measurement

20 science standpoint, if you have got a complex

21 construct under the microscope, then you

22 probably, it is a multi-dimensional complex

1 construct, that is when you get into the
2 position of having to create composites of
3 thing that you are measuring, like math is a
4 complex construct. There is algebra. There
5 is geometry, there is calculus, blah, blah,
6 blah. And each one of those things needs to
7 be represented correctly.
8 Whereas you are counting discrete
9 events or episodes like you are trying to
10 measure maternal mortality, you count mothers
11 who died. You know, it is not as complex a
12 measurement exercise. It still has all the
13 measurement issues associated with it,
14 precision and validity, but it is a different
15 exercise than trying to measure complex
16 constructs. So if you are trying to measure
17 quality of care for the whole hospital, that
18 is a very different purpose that you are
19 trying to accomplish with the measurement task
20 you have in front of you than if you are
21 trying to count bodies, you are measuring
22 mortality rates for hospitals.

1 So just to sort of -- each one of
2 those things is a different category optimal
3 vascular care is a complex construct by
4 definition.
5 DR. BURSTIN: Again, the intent of
6 this was to just really not to get into the
7 details of the measures but just to show you
8 some of the issues you have so when you get to
9 the guided discussion with Liz and Patrick,
10 some of this will make hopefully some context
11 will be helpful here. So that is just the
12 first example. Again, specifically brought up
13 this example because it was people view it as
14 a complex construct that made sense at some
15 level but didn't necessarily think the
16 individual measures rose to the level of being
17 endorsable as stand-alone measures.
18 The second example here I included
19 specifically because of harmonization issues.
20 So this is the optimal vascular care measure
21 that I mentioned that comes out of Minnesota
22 Community Measurement, which includes these

1 four components of LDL, blood pressure
2 control, tobacco-free status and daily aspirin
3 use. And part of what the committee wound up
4 doing was harmonizing it and actually they did
5 harmonize to the blood pressure control level
6 that we already have for the individual stand-
7 alone measure. But for example, there is no
8 measure of tobacco-free status. There is a
9 measure of offering help with smoking
10 cessation and counseling but tobacco-free
11 status is not a measure. Daily aspirin use is
12 a measure only in a claims-based measure we
13 have got which is somewhat problematic because
14 it is not often on the med list but hopefully
15 we will be going forward.
16 And so at the end of the day, this
17 was endorsed as the composite and yet
18 submitted on a single form as an all-or-none
19 composite. So the committee never actually
20 had the chance to say should any of those
21 individual components go forward but the
22 thought was at least at the end of the day

1 please have it harmonized to the individual
2 measures we have already got, which is what we
3 attempted to do around LDL and blood pressure
4 for example.
5 DR. CHASE: Just to make a comment
6 there because it struck me as you went through
7 that that one of the challenges of why this
8 can occur, too, is when you put together a new
9 composite sometimes the individual components
10 have a different basis so when they were
11 constructed. So the denominator might be
12 slightly different or so forth. So sometimes
13 I think that is what is driving -- what we may
14 run into and we need to be able to recognize
15 that when you actually implement these
16 sometimes you need to construct them
17 differently because you are trying to get --
18 your construct is different. It is trying to
19 get at something else than the individual
20 component was.
21 DR. BURSTIN: Right and that has
22 been a challenge in terms of the denominator

1 for all-or-nones being different than the
2 denominator for the approaches that often are
3 taken with the composites of weighted
4 measures.
5 And the last measure I put up
6 there just as an example is the patient safety
7 for selected indicators measures that AHRQ had
8 put forward. And the reason I put it up there
9 again is there are several measures in here
10 that as part of the initial evaluation were
11 not endorsed and yet thought as a general
12 construct and this was done by the first
13 committee, that they were appropriate for an
14 overall sense of patient safety, even if they
15 didn't feel like they were necessarily
16 measures that would stand alone.
17 So for example there is a measure
18 there about selected infections due to medical
19 care and concerns that well we have already
20 got measures from the CDC's National
21 Healthcare Safety Network, NHSN around CLABSI
22 and others and do we want claims-based

1 measures that would compete and not
2 necessarily agree with what people consider
3 the gold standard?
4 So again, just give this to you
5 more as a sense of these are the kinds of
6 issues we have encountered. So as we go
7 through the more formal discussion with the
8 chairs, I think you will have a sense of at
9 least what some of these terms means. Because
10 it is a confusing space for us.
11 DR. ROMANO: I think part of the
12 issue there, too, is with the reliability of
13 the individual components. So one of the main
14 reasons for constructing a composite is to
15 extract information from multiple measure that
16 may be relevant to a quality-related concept.
17 And to that end, some of those components may
18 not be able to stand on their own merits in
19 terms of having sufficient reliability for
20 public reporting at the provider level.
21 And given that NQF has kind of
22 raised the bar there to say that all the

1 measures have to be sufficiently reliable for
2 recording at the provider level, that is the
3 main reason to create a composite is to
4 enhance that reliability.
5 DR. BURSTIN: And that is
6 something I think we would love to have more
7 discussion about is understanding that leap of
8 saying it is not okay in an individual
9 measure. When you put them together it
10 increases reliability. It something I think
11 we will need to spend some more time on.
12 Did you have a comment on that
13 Dave?
14 DR. SHAHIAN: So could one
15 theoretically then have an NQF-endorsed
16 composite, none of whose components would pass
17 muster individually as an NQF-endorsed metric
18 and is that what we want?
19 DR. BURSTIN: We haven't had any.
20 It is a little hard to imagine. But again, I
21 think that the one place it could be is
22 potentially as an all-or-none, where there may

1 be that the elements as constructed might be
2 slightly different. They may be the same
3 concepts but again because of the denominator
4 issues they may look somewhat different.
5 I mean we didn't, for example,
6 endorse the individual measures under optimal
7 vascular care, they were not submitted as
8 such. It was an all-or-none. And yet it was
9 interesting because when it actually came up
10 as part of the, I believe it was the ACO
11 payment. They really loved this measure and
12 I believe chose it but wanted to use the
13 individual components. And we are like,
14 actually we have never look at the individual
15 components of this measure. It was submitted
16 as an all-or-none.
17 So these are tricky issues for us.
18 I don't know the answer to that, David.
19 DR. SHAHIAN: I mean I think we
20 all know that we are dealing with a
21 proliferation of measures. And I am a little
22 concerned about the concept well for the

1 composite we need to have a slightly different
2 measure of the LDL or a slightly different
3 smoking measure than we do for this endorsed
4 NQF measure.
5 Then we have got people trying to
6 deal with 15 different smoking measures. That
7 is just the wrong direction to be going, I
8 think.
9 DR. ROMANO: I think we will come
10 back to that question a little bit more in the
11 discussion.
12 DR. BURSTIN: Yes, definitely.
13 MS. JOHNSON: We've already talked
14 somewhat about the evidence for each
15 component. Again, they may not meet our
16 updated guidance because it has gotten a
17 little bit more stringent. But even for
18 component measures on our current composite
19 measures where they were previously endorsed,
20 it depends on when that endorsement happens.
21 So as the individual measures come back up
22 from maintenance review our evidence guidance

1 again has become more stringent and those may
2 lose endorsement.
3 Another problem that we have
4 noticed as we have gone through is just asking
5 about the purpose and quality construct that
6 is part of our questions that we asked about
7 composite measures. Those aren't always
8 adequately explained or maybe even simply
9 explained. It is sometimes hard to understand
10 just what the quality construct is for some of
11 these measures.
12 And then in terms of the measure
13 specifications, they are often insufficient.
14 Sometimes because they are just incomplete,
15 things just weren't answered.
16 Often though, things are answered
17 but it is hard to understand either what they
18 did or maybe why they did it and then
19 difficult to evaluate the analysis. I'm not
20 sure we can do a lot about the last part
21 because these are just complex analysis and
22 not everybody has the statistical knowledge to

1 be able to understand every little thing but
2 these are some of the issues that we have run
3 into.
4 DR. DE LONG: I was just going to
5 ask if this is an issue for us. I mean the
6 incomplete and difficult to understand should,
7 I would think, be turned right back. Now, the
8 analyses could be a different issue but it
9 seems that we wouldn't entertain something we
10 couldn't read.
11 DR. BURSTIN: I think the issue is
12 yes, we do try to work with measure
13 developers, try to get information as complete
14 as possible. I think sometimes the problem is
15 it is actually hard to understand what we
16 mean. So part of what our current efforts
17 have been around our new work we have been
18 doing around process improvement around our
19 business development process and just have
20 been piloted a two-stage process has actually
21 been coming up with guidance that says what
22 does good look like. What does this actually

1 mean? And I think part of what is also really
2 not clear for what we have asked people to
3 submit around composites is what is required.
4 So that half the time people may submit
5 something they think is complete but through
6 our lens it may not be. Or it comes to the
7 committee and they are like well that is
8 wholly inadequate. Well, it kind of meets
9 what it says on paper. So I think again,
10 being able to clearly say to developers this
11 is what is required, this is what good looks
12 like, I think will help us all a lot.
13 So we need your help in making
14 sure we are really asking for just what is
15 needed and nothing more because again, a good
16 number of you have submitted to NQF, it is not
17 an easy process. There is a lot of
18 information and so we don't want to ask people
19 to submit a lot of information committees
20 won't ultimately use. So you want to make
21 sure you are really honing in on what they
22 need to submit and the right way to get it

1 evaluated.

2 DR. ZASLAVSKY: Can you give a

3 sense of how much of the work you are doing

4 with these measures, typically these

5 composites is really going through the

6 components and how much of it is looking at

7 the way it is composited? This seems to be

8 just emerging as an issue that the evaluation

9 of the components is becoming a major problem

10 in itself and then thinking about whether the

11 way you evaluate them is different.

12 I could see how, this may be a

13 separate point, that it is a big difference

14 between saying this is a component that

15 wouldn't stand by itself because of a variance

16 and lack of reliability and saying it is a

17 component that wouldn't stand by itself

18 because of bias because it is measuring the

19 wrong thing or it would unfair to some

20 institutions or something like that.

21 And I am not sure how much of the

22 work is going to which side of these two

1 problems.
2 DR. BURSTIN: I think it really
3 depends on the measure. It is very measure-
4 dependent. I think there is ones when it has
5 been much more about the construct and there
6 are times when it is more about the
7 components. And I think our goal is to figure
8 out what that right balance is.
9 You know, for example, we just
10 evaluated a very extensive perinatal maternal
11 and child outcomes composite really nicely
12 done. Some of the individual components were
13 very exciting. It wasn't risk-adjusted. And
14 at the end of the day 90 percent of the
15 discussion was about the construct of risk
16 adjustment for an outcome measure like that.
17 And actually not as much about the individual
18 components that everybody agreed were
19 important but not risk-adjusted.
20 So it really is very, you have
21 seen one composite at NQF and you have seen
22 one, I think is truly where we are.

1 So the more we can try to make
2 sense of that, the better.
3 DR. BIRKMEYER: I think with
4 regard to that last bullet, I think there is
5 a couple of issues. And I think the easier
6 one to deal with is just the problem of
7 applications that just aren't clear or are
8 incomplete. I think the tougher challenge and
9 one that value judgments will have to be made
10 are with regards to the more complex
11 statistical or econometric-based of composite
12 measures that may be as clear as they can
13 possibly be but couldn't possibly be evaluated
14 or couldn't be replicated by a large majority
15 of hospitals or users.
16 And that is where I think, that
17 and composite measures are just fundamentally
18 different from the usual business of NQF in
19 evaluating individual indicators.
20 MS. JOHNSON: Okay, and just a
21 little bit more information because we thought
22 you might want to know. We have had six

1 composites that are not currently endorsed and
2 I just wanted to walk you through some of the
3 reasons.
4 One is lack of variability and
5 overall high performance. This came through
6 the central line bundle composite. So that
7 one, basically performance rate was very high
8 at 95 percent. So there was little
9 opportunity for improvement and that is why
10 that one went down.
11 There was lack of evidence
12 supporting components on an all-or-none
13 measure. That one, an example of that with
14 the ventilator bundle measure. And what
15 happened there, it was actually withdrawn by
16 the developer and because of lack of strong
17 evidence to support the measure focus, the
18 current national effort to define ventilator
19 complications and also I think the developer
20 may not have intended the measure to be used
21 for public reporting. So again, lots of
22 reasons the developer decided to withdraw that

1 one.

2 Patrick could probably talk to why

3 one of the AHRQ composite measures was

4 withdrawn. I actually couldn't find that

5 information but again, that one was withdrawn.

6 DR. ROMANO: We actually don't

7 think it was withdrawn. So that is a separate

8 conversation.

9 MS. JOHNSON: Oh. So we will get

10 together offline and try to figure out what

11 happened with that. Maybe I just have the

12 wrong one.

13 The component performance measures

14 were not endorsed and did not meet criteria.

15 Helen already gave you that example. It was

16 the perinatal adverse outcome index. And

17 again the problem with that one is the outcome

18 measures, the components were not risk-

19 adjusted. So they did not meet our criteria

20 around scientific acceptability.

21 Composite measures included some

22 performance measures that lost endorsement or

1 missing data had a substantial impact. That
2 happened with the composite measure of
3 hospital quality for AMI. That one was a new
4 measure that we evaluated in 2010 but it had
5 a smoking measure that was no longer endorsed
6 by NQF and apparently there was a lot of
7 missing data that was handled by imputation
8 using national means. And that was just not
9 felt to be good enough to pass that measure.
10 And then finally some component
11 measures that were more representative of
12 quality of care were not included in the
13 composite measure. That was another CMS
14 measure of hospital quality for heart failure
15 and that measure specifically didn't have
16 components that dealt with beta blocker use,
17 better discharge measures in cardiac rehab.
18 So the committee evaluating that measure felt
19 that all of the right components just weren't
20 in the measure. So that is why that one went
21 down.
22 So back to Helen's point, every

1 measure is different. Every composite measure
2 came in differently and possibly went down for
3 many different reasons.
4 MS. PAGET: I think you have
5 already answered my question but we then make
6 the assumption there was no overlap. So each
7 non-endorsed measure is not endorsed for a
8 different reason. We are not seeing patterns,
9 for example.
10 DR. BURSTIN: I don't think we are
11 seeing patterns other than I think some of the
12 issues we have already brought up. But I
13 think also the patterns we are seeing is this
14 issue of the components within a composite.
15 So people may sometimes like the construct but
16 not the components. Or people sometimes like
17 the components but the contract is not risk-
18 adjusted. So I think it is kind of all over
19 the map but interesting this last one as well,
20 you know, we are currently looking at a
21 colonoscopy composite that is being reassessed
22 by our GI committee, for example. You know,

1 one of the concerns was those are some of
2 those indicators as part of the composite were
3 really important and useful. But at the end
4 of the day, the GI folks in particular thought
5 the best way to really look at the quality of
6 a colonoscopy is your adenoma detection rate
7 and all the rest of it was kind of on the path
8 towards getting at what is really important
9 and that wasn't part of the measure.
10 So often times I think we are also
11 hearing this issue of is it really capturing
12 truly the quality construct you care about
13 that the composite is allegedly trying to
14 represent. Exactly. Missing components, yes.
15 DR. DE LONG: Can I ask? On that
16 last point, does the composite have to be
17 comprehensive and where, for example the heart
18 failure one, apparently the components are all
19 individually endorsed and are used as stand-
20 alone measures. Is that correct?
21 DR. BURSTIN: Yes, although many
22 of those measures were topped out, really,

1 really high levels of performance. A couple
2 of them so topped out or in one case the
3 smoking measure had been reviewed by NQF and
4 we didn't really believe it was a valid
5 indicator of smoking cessation in hospitals.
6 It had become sort of a complete checkbox
7 measure. So it was not endorsed. Most of the
8 others were topped out. And so again this
9 issue of what do you do with a composite that
10 essentially gives you information that is not
11 a whole lot different than the individual
12 measures.
13 DR. DE LONG: Okay, my question
14 was a little different.
15 DR. BURSTIN: Okay.
16 DR. DE LONG: In terms of, for
17 example, beta blockers for heart failure, it
18 was not included in the composite but
19 presumably it is a measure that is being used
20 on its own already endorsed. Is that not the
21 case?
22 DR. CHASE: Well I would have an

1 opinion on that, which is I don't think a
2 criteria should be the reviewers could come up
3 with other things that could be included in
4 the composite because that may not be the
5 purpose of how the measure was constructed.
6 And our example in diabetes care, for example,
7 there are some things about treatment that
8 aren't in there because that measure was
9 constructed around a risk reduction. So as
10 you know in diabetes care, the other things
11 like the foot exam that might be really
12 important for care but it wasn't what the
13 purpose of the measure was.
14 So I think it would be dangerous
15 to sort of have committees saying we would
16 like this to be more inclusive when that may
17 not have been the original intent.
18 And while I hope we get to this as
19 we talk later I saw on the construct of this,
20 composite measure, people who are presenting
21 those should be able to articulate what is the
22 purpose of the composite. Why did you

1 composite things?

2 And then the test should be is it

3 doing what you intended it to do. Which may

4 not always be everything about a particular

5 case. We weren't trying to construct this to

6 try to cover everything about a condition.

7 DR. DE LONG: And I still want to

8 go back to for example Dave said that there

9 have been a proliferation of measures. And I

10 don't think every measure that is being used

11 is a composite.

12 DR. BURSTIN: No.

13 DR. DE LONG: There are single

14 measures.

15 DR. BURSTIN: Right.

16 DR. DE LONG: And if they are

17 being used on their own, for example beta

18 blockers after a heart attack, you wouldn't

19 necessarily want to double count them as

20 including them also in a composite,

21 necessarily.

22 So leaving out some measures that

1 are already endorsed on their own and felt to
2 be sufficiently important, it seems to me we
3 have to decide. Do they go in a composite or
4 do they stand on their own and not have a lot
5 of overlap there?
6 DR. BRATZLER: Patrick?
7 DR. ROMANO: Go ahead, Dale.
8 DR. BRATZLER: Yes, thanks. The
9 other things that I think has to come into the
10 discussion, we will probably talk about it
11 some later, is the issue of unintended
12 consequences of the composite.
13 So Helen gave the example of
14 composites that were built with largely topped
15 out measures. But particularly if you have a
16 composite where you have a number of
17 relatively high rates of performance, you have
18 other components of the composite that have
19 lower rates of performance the consequence of
20 the way to improve your performance rate is to
21 focus on those aspects of the composite that
22 have low rates of performance or the biggest

1 denominators, which may or may not be the most
2 important components of care that might result
3 in better patient outcomes.
4 So there are a lot of unintended
5 consequences that can come up when you group
6 measures together.
7 DR. ROMANO: Well I am just
8 mindful of the time and I don't know -- we do
9 have some questions that we want to discuss
10 specifically. But if there are additional
11 questions related to Karen's presentation or
12 comments on Karen and Helen's presentation, we
13 should get those on the table now.
14 If there are more general
15 questions related to our discussion of
16 conceptual framework and so forth, maybe we
17 could hold those for a minute or two.
18 DR. KAPLAN: This is just sort of
19 wrapping around the final points that were
20 being made, which is again, what are we
21 measuring? What are you measuring? If you
22 are measuring discrete events like beta

1 blockers following something like that, you
2 are measuring a discrete event. And the
3 measure is good for that purpose and only that
4 purpose.
5 If you are trying to use that
6 measure like two trains left Chicago traveling
7 at a distance of and you are trying to use
8 that to measure something else, that is when
9 you get into trouble and these complex
10 constructs have to be defined.
11 If we don't define what are you
12 trying to measure here and you are using that
13 to measure all of the quality of diabetes care
14 and there are things like foot exams that are
15 relative to that, that is the construct you
16 have got under the microscope. So specifying
17 that has to be really critical when you are
18 talking about these composites.
19 DR. BURSTIN: I think part of the
20 challenges we have seen is sometimes people
21 get so focused on the components that they
22 sometimes get lost and don't get to the

1 detailed, this is the complex construct. Not
2 all the time but sometimes it has been a
3 struggle to say, you know we will ask for
4 quality construct and what they will do is a
5 recitation of the components. Like no, no,
6 no, what is the construct?
7 DR. ZASLAVSKY: I have a question.
8 This is sort of more about how NQF sees its
9 role.
10 Suppose that you have three
11 different groups come in either at the same
12 time or at different times and they want to
13 develop a composite or get approved a
14 composite for a certain construct and they are
15 even using these same components and one of
16 them says we are going to equally weigh them.
17 Another one says we are going to use factor
18 weights. Another one says we have some kind
19 of criterion-based regression and we have done
20 it on some dataset that we have and here is
21 another set of weights. Is it your role as
22 NQF to pick one of these or to let a thousand

1 flowers bloom, or the first one past the gate
2 is it and the next one has to overthrow it?
3 How do you see your role in that kind of
4 situation?
5 DR. BURSTIN: It is a tough role
6 but it is one people increasingly look to NQF
7 to really try to sort out. Again, the
8 proliferation of measures David mentioned the
9 cacophony some might say, there are so many
10 measures at this point that are slightly
11 different, slightly competing with each other
12 that actually have done a lot of work,
13 particularly in the last year trying to figure
14 out exactly how we assess related and
15 competing measures which is what we call them,
16 when it is actually trying to come up with
17 some sets decision rules about when two
18 measure can move forward. For example, the
19 same measure harmonized different settings of
20 care or different data sets, potentially could
21 still move forward as long as they are
22 harmonized.

1 But when things are truly
2 competing, we really do try to have as much as
3 possible committees try to go through them and
4 say which of them is actually best in class or
5 superior. It is often very difficult to do.
6 We don't have data runs for example to be able
7 to go back and say head-to-head, if ideally
8 you could have this measure and this measure
9 of construction on the same dataset, it is
10 often an impossibility.
11 But we do try to, as much as
12 possible, pick what we think is the best in
13 class. And if that is not possible, sometimes
14 we will move both forward. I mean, one
15 example is at the time of the diabetes project
16 in our outcomes project about a year or so
17 ago, we had the all-or-none composite on
18 optimal diabetes care from Minnesota Community
19 Measurement. We also had the weighted
20 composite out of NCQA. At the time, the
21 committee tried very hard and at the end of
22 the day could not say one was necessarily

1 superior. For different end users, one might
2 fit better than another did and they thought
3 the constructs were different enough. And
4 again, we worked with the two developers such
5 that the components within them were
6 harmonized. Meaning that for the individual
7 clinician or somebody being measured, the
8 blood pressure control was the same. The A1C
9 is the same. The lipids are the same. So you
10 have at least harmonized on science but we
11 can't always harmonize on the approach.
12 So for now at least we allowed
13 both of those to move forward, recognizing
14 different end users might use them. And
15 hopefully, as we gain experience, we will have
16 a better sense of that.
17 Sometimes the committees are much
18 more clear. I mean, the cardiovascular
19 committee just came down and could not have
20 been more clear that at this point in time in
21 cardiovascular care an all-or-none was the
22 appropriate approach because these were things

1 that should absolutely always be done to move
2 the needle.
3 But again, this is where I think
4 we still see variability of cross committees,
5 which is why we wanted to bring you guys
6 together to try to have some guidance we could
7 share with the committees that they would
8 always act more consistently.
9 DR. ROMANO: I think this is
10 something else that we will tee up for
11 discussion a little bit later but I know in
12 the case of the AHRQ composites, we actually
13 offered three different weighting schemes and
14 said that different users may apply different
15 weighting schemes, depending on their
16 particular decision-making context and we can
17 talk more about that a little bit later.
18 But it ended up that one of those
19 weighting schemes became the NQF-endorsed
20 weighting scheme. But the other schemes are
21 still out there on the table for other users.
22 So it is an interesting question.

1 MS. JOHNSON: Okay, so now I think
2 we should just go ahead and hand it over to
3 Patrick and Liz to do the guided panel
4 discussion. And I'm not sure how you want to
5 do that. We have a list of questions that we
6 hope you will address and I will just let you
7 decide if you want to go through them one at
8 a time or how you want to do that, Patrick.
9 DR. ROMANO: Well, I think
10 obviously we didn't get a chance -- I'm sorry
11 about the train but I think maybe what we will
12 do is to start by talking about the conceptual
13 model. And I think it has already come
14 through in the discussion so far that most of
15 us feel strongly that there should be some
16 conceptual framework for a composite that the
17 developer should be able to articulate a
18 conceptual framework.
19 But the question is is this, there
20 is a model one, model two that is presented.
21 There are a variety of terms. So let's start
22 out by discussing that, if that is an

1 appropriate framework. And then I think we
2 should discuss a little bit about maybe what
3 is not on the table today, what we are not
4 going to consider as composites for the sake
5 of the discussion the rest of the day. And
6 then we can move into some of the other
7 questions. Does that seem fair?
8 MS. JOHNSON: Yes and I do want to
9 just make sure that we understand that we are
10 not saying that XYZ measure is not a composite
11 but just that we might not need to apply extra
12 criteria to evaluate some measures. And that
13 is how we try to construct those tables. So
14 as long as we are good on that.
15 And I think the other thing about
16 those tables is it was just our effort to put
17 something out there. We don't want to get
18 bogged down in taxonomy and all that kind of
19 stuff but hopefully that might be a guide to
20 help us at least know what we are talking
21 about when we are talking about things.
22 DR. ROMANO: Thank you and I

1 really want to compliment the staff work that
2 was done in preparation for this meeting. It
3 was really a very impressive compilation of
4 resources and organization of the key
5 questions. So it really gives us a great
6 foundation for this discussion.
7 So in this memo, NQF staff have
8 sort of put forward these two general models
9 that are described in the field and it is
10 interesting I have heard before the
11 psychometric versus clinimetric distinction
12 but then I read David Streiner's argument here
13 that this is a distinction without a
14 difference.
15 On the other hand, then when I
16 read his second paper, it was like well, he is
17 really talking about the same thing. He talks
18 about it in terms of scales versus indexes.
19 Other people use the term formative versus
20 reflective. Other people talk about whether
21 the indicators are causing the construct or
22 the construct is causing the indicators.

1 But really all of these, it seems
2 like, are different semantic ways of
3 describing the same fundamental distinction,
4 recognizing that the specific approaches that
5 might be used for evaluation are on a
6 continuum really. And so with one model you
7 might emphasize certain approaches, with
8 another model you might emphasize other
9 approaches. But let's just put that on the
10 table for discussion. Do people find this
11 helpful or not? Where should we go?
12 DR. KAPLAN: When Alvin Feinstein
13 first cooked up clinimetrics he used to accuse
14 those of us who were trained in a different
15 discipline as worshiping at the altar of
16 psychometrics. And so I have learned over the
17 years to call it measurement science and it
18 gets you out of a lot of touch calls with your
19 clinical colleagues and your psychologically
20 -- measurement science is really at the base
21 of everything and it doesn't matter what is
22 under the microscope. All of the principles

1 apply.

2 DR. SHAHIAN: And just to add to
3 support to what you just said, I don't know
4 who put this particular dichotomy together in
5 terms of conception models one and two, but I
6 can tell you that having the STS CABG
7 composite as an example for concept two, that
8 is not the way we thought of it. And in fact
9 we spent probably over a year evaluating this
10 model from a psychometric from a traditional
11 psychometric perspective.

12 So at least that is the way I went
13 about it. And I think most of the people on
14 the team, Liz might want to comment, but -- so
15 I don't really think it is appropriate to list
16 STS as an example of the clinimetric.

17 DR. DE LONG: I think we are
18 getting into semantics. As a matter of fact,
19 on the phone the other day we discussed
20 whether it really matters how the metric
21 actually came into being. What really matters
22 is what it reflects and whether it is

1 reliable, whether it could be reproduced and
2 it can be used to improve quality.
3 So that may even relieve you from
4 your having to take a part all the methods and
5 put them back together if the developer can
6 actually produce something that leads people
7 like John's company to be able to implement
8 them and they work --
9 DR. BIRKMEYER: I didn't say that.
10 DR. DE LONG: -- then maybe you
11 have got a good measure.
12 DR. BIRKMEYER: I have got very
13 mixed feelings about whether the single most
14 important thing that we need to start with is
15 that there be a conceptual model in place.
16 I totally agree with Sherrie that
17 the most important thing is to be clear what
18 at the end of the day that you are trying to
19 measure and the need to work backwards and see
20 whether that goal is being met why whatever
21 the measure is.
22 But I think, and I am reflecting

1 my bias as a simple country surgeon, that kind
2 of at the end of the day, there is a lot of
3 measures out there that really get you to the
4 end result of what you are trying to achieve
5 and you don't actually know exactly why that
6 measure was the best one to get you there.
7 DR. ROMANO: Well just to pose a
8 practical question. So I agree completely
9 with sort of banning the terms clinimetric and
10 psychometric and focusing on measurement
11 science and recognizing that this distinction
12 between model one and model two is really a
13 spectrum, perhaps, and not two bins that you
14 have to go into bin A or bin B.
15 But to give an example with
16 David's measure, so you explicitly looked at
17 internal consistency reliability. But someone
18 else approaching this same question might say
19 that they don't care about internal
20 consistency reliability because they are
21 looking at five different types of outcomes or
22 complications, if you will, of cardiac surgery

1 and it doesn't matter whether those hang
2 together. Some clinicians may do better at
3 preventing A. Others may do better at
4 preventing B. But from the patient
5 perspective, they are all bad things.
6 And so from the patient
7 perspective, it makes sense to add them up in
8 some way. So how would you respond to
9 somebody else who said no, we are going to
10 construct this measure without regard to
11 internal consistency reliability because we
12 are approaching it from a different
13 perspective.
14 DR. SHAHIAN: I guess my personal
15 bias is that I guess I am somewhat of a
16 traditionalist. I would probably, I think
17 tend to be more along Sherrie's way of
18 thinking.
19 I think if we haphazardly combine
20 things just for the sake of combining them and
21 don't know whether item B adds value to item
22 A as a stand-alone in evaluating the

1 underlying latent construct, or if we don't --
2 if they are totally redundant, these are
3 important considerations. And I think frankly
4 there is all too much of this sort of just
5 haphazard pick a bunch of things, and put them
6 together and call them a composite.
7 I would rather, personally, see a
8 more traditional measurement science approach.
9 That is my personal bias.
10 DR. ZASLAVSKY: I have to say that
11 I have been through this argument over and
12 over in development of the CAHPS surveys. And
13 I can't help agree with what Patrick is saying
14 about there being these different perspectives
15 that do lead to different decisions,
16 especially about, not necessarily so much
17 about how you composite once you know what you
18 are compositing, but about what you need to
19 put into the composite in the pursuit of a
20 high alpha leads you in the different
21 direction than sometimes what you will get if
22 you are trying to group things that you think

1 are similar more in the way that Patrick
2 describes as not necessarily being empirically
3 related but being conceptually related or to
4 a similar criterion outcome variable.
5 So I would love to be able to not
6 have this be an argument but I think that
7 these do sometimes pull in different
8 directions.
9 DR. KAPLAN: This is one of the
10 times when I think Alan and I can actually
11 reach common ground about perspective because
12 I think getting the tyranny of psychometrics,
13 if you will, has come out of real traditional
14 latent construct. I have things I can measure
15 about you that get to your IQ, et cetera, et
16 cetera. And sometimes we shoot more in
17 techniques for getting to reliability.
18 Things like physician-level
19 reliability, well how do you tell whether
20 using a set of things about diabetes care, for
21 example, whether those measures are a reliable
22 estimate of physician's performance. The sort

1 of traditional internal consistency of
2 reliability may not be the right approach for
3 that particular measurement task. And then
4 you need to look at intraclass correlation or
5 has the physician got a thumbprint. Is the
6 physician behaving consistently across
7 patients within their practice? So the
8 technique and approach may be different for
9 the different measurement task we have at
10 hand.
11 And I would not like it or maybe
12 it is -- you know, I hate to test reliability
13 but maybe that is the right approach. There
14 are all other kinds of techniques that you can
15 use to get to capital our reliability and I
16 don't want us to -- I wouldn't like to see us
17 get bogged down in one "disciplinary
18 perspective."
19 DR. SHAHIAN: I think each of
20 those methods that you are talking about is a
21 measurement science approach. I am not wedded
22 to Cronbach's alpha but all the things you

1 mentioned have an empirical basis.
2 DR. KAPLAN: Absolutely.
3 DR. SHAHIAN: That is all I'm
4 saying.
5 DR. DE LONG: And Alan I think was
6 the first person to say the word outcomes.
7 And it seems that what we really are driving
8 at is something that improves outcomes and it
9 doesn't matter so much how much it was
10 internally consistent or whether it all
11 reflects the same thing. I do agree, they can
12 reflect different components that are not
13 necessarily tied together.
14 MS. PAGET: Just a couple
15 questions. I think I brought this up on our
16 call but my question to the experts here in
17 measurement, do we see this same kind of
18 debate or tension exist in other industries,
19 most specifically I am wondering about
20 educational testing that uses a lot of
21 composite measures. And then my second
22 question I guess maybe is for Helen is how

1 important is it that this group and NQF fall
2 down somewhere on this issue? I mean is it a
3 deliverable of this group to really state
4 something about the conceptual model?
5 DR. BURSTIN: I'll answer the
6 second question. I don't know that we have to
7 say that. I actually think Patrick's comment
8 earlier I think it was Patrick that we
9 potentially will be needing a spectrum. I
10 just think we have to have some guidance for
11 the committees to say what level is
12 acceptable. If they are both acceptable and
13 they are just variants of the spectrum, all
14 based in measurement science, I am fine with
15 that.
16 And I think even as the team was
17 putting this together there was a sense that
18 how much gray is there between these first two
19 models? I just wanted to apologize for
20 mischaracterizing the CABG composite. I just
21 wanted to have something to put together to
22 put in front of you because we do get very

1 different approaches that people bring to us.
2 If either is fine, okay, good. I don't think
3 we need to pick one necessarily.
4 MS. PAGET: Yes, just wanted a
5 particularly educational -- does this kind of
6 question exist or are they -- before, after,
7 in the middle?
8 DR. ROMANO: Well it is
9 interesting that you raised that question
10 because that question really was what inspired
11 Jeff Geppert's paper, which I think was part
12 of the packet which is currently under review,
13 which is a belief that in some other fields,
14 particularly in financial services, there is
15 a very strong emphasis on what is the
16 decision-making context for a composite. So
17 when a composite like the Dow Jones Industrial
18 Average, for example, or the consumer price
19 index is created, there is a lot of thought
20 that goes into how are people going to use
21 this to inform their decision-making and let's
22 construct the composite in a way that produces

1 the right signal that encourages the right
2 allocation for effort, if you will, the right
3 investment of resources across different
4 sectors.
5 So I would like to put that out
6 for discussion for a couple of minutes to see
7 because to me that gets back to the concept of
8 different weighting schemes and why AHRQ
9 actually offered different weighting schemes.
10 Because if the approach is, for
11 example, we have an indicator that is called
12 patient -- it is a mortality across multiple
13 procedures. And it composites mortality,
14 risk-adjusted mortality, for different types
15 of procedures. And it was not endorsed. The
16 committee was concerned that it was too
17 heterogeneous because it was bringing together
18 different types of procedures done by
19 different types of surgeons.
20 But there could be a counter
21 argument made that in the right decision-
22 making context, it would be important to

1 signal what the hospital's overall quality was
2 for surgical procedures. And that it might be
3 useful for the hospital to understand
4 something about what is driving that overall
5 performance.
6 So that is a case where perhaps
7 what we should be thinking about more maybe,
8 instead of focusing so much on how these
9 building blocks are put together, maybe we
10 should be focusing more on what is the
11 decision-making context. How do we want
12 people to use this and is the composite
13 constructed in a way that is consistent with
14 that use?
15 DR. KAPLAN: Again it gets back to
16 what you are trying to measure because
17 educational settings and educational
18 circumstances have cognitive performance often
19 -- usually as their base and that is a
20 different enterprise, measuring cognitive
21 performance from behavioral performance which
22 is usually what you are trying to get at when

1 you are looking at many of the measures of
2 quality. It is the performance of something.
3 And in case of outcomes, it often has somebody
4 else's performance at its base. So behavioral
5 and cognitive are two different exercises by
6 far because those -- and now teachers' pay-
7 for-performance by the way is trying to use
8 students' performance on standardized testing,
9 so I can compare the same test across students
10 to reinforce teacher performance, as an
11 estimate of teacher performance. But it has
12 the advantage of being standardized because it
13 is cognitively based and it has the advantage
14 of being widely tested on a lot, a lot of
15 folks so we know a lot about that measure at
16 the student level.
17 But now we are looking at patient-
18 level variables and we are trying to wind them
19 up to estimate physician level performance and
20 then we are trying to wind that up to measure
21 clinic or institution-level performance. So
22 we have got a different -- the behavioral

1 stuff is a very, very different measurement
2 exercise. It still needs to respond to what
3 are you trying to measure and all the things
4 about that and are you able to do it
5 consistently and are you able to do it with
6 some level of accuracy?
7 DR. BIRKMEYER: So just to follow
8 up with that, I totally agree with the point
9 that Patrick just made that while being clear
10 about what you are explicitly trying to
11 measure, you can sometimes only answer that
12 question if you consider it in the decision-
13 making context and what types of judgments are
14 people trying to make at varying levels of
15 altitude. The challenge, of course, though,
16 is that runs counter to the NQF mantra of we
17 consider measures sort of agnostically with
18 regards to their application and maybe like
19 that is why composites may be different.
20 DR. DE LONG: I think there is
21 another issue that was in one of the
22 references you sent and I can't remember which

1 one. But there was an experiment where they
2 took two different datasets and tried out five
3 different methods. And there was almost no
4 consistency in the results. The top
5 performers for one dataset were by one method
6 top and by another method bottom. I think
7 when we look at why we are developing these
8 measures we also need to be thinking about
9 whether they hold up. Whether, for example
10 when the developer puts them out there, they
11 maybe had a big enough sample to split it and
12 see if that measure actually performs the same
13 way in the other half of the data. And I'm
14 wondering if something like you are suggesting
15 the reason this is connected to your comments
16 is that maybe when you get something so broad
17 as surgical mortality for a whole bunch of
18 different surgeries, that really isn't -- once
19 you combine it, you are not reflecting
20 something that is stable. I don't know.
21 DR. CHASE: So kind of back to
22 your question I think about do we -- is it

1 worth spending more time about these two
2 different models? I would be more on the side
3 of no. I am reflecting into what our purpose
4 here -- it would be a really interesting
5 discussion for us here but when sort of this
6 gets applied at NQF, I think we are trying to
7 get to advice for reviewers about what is
8 different about composite measures.
9 I don't think it is going to be as
10 practical when you get down to so what are --
11 unless and I couldn't find this about what I
12 would say. Oh, if you fall into this bin, you
13 have to do these things. And if you fall into
14 this bin, you have to do these. I think in a
15 couple of the other models we do, but the
16 distinction in the first two I was getting a
17 little bit lost. And maybe that is the other
18 thing that I would say about this is is
19 probably a lot of your measurement developers
20 and the reviewers might get lost by this
21 terminology, too. And then it is not going to
22 be helpful.

1 So I would encourage us maybe to
2 move down the list and deal with what are some
3 of the criteria around the other ones. But
4 that would just be my thought here.
5 DR. DUNTON: If we wanted to
6 divide up the world, --
7 DR. BRATZLER: This is Dale. I
8 think I also agree with that.
9 DR. DUNTON: I think that rather
10 than think about the model, it might be useful
11 to think about a composite of process
12 measures, versus a composite of outcomes.
13 Because the question for the process measures
14 is was optimal care provided. It could be all
15 or none, a percent of the time, or something.
16 But if you are looking at safety in terms of
17 outcomes, it is probably less likely that you
18 are going to get really reliable measures than
19 you would if you are looking at was care
20 provided. And so the measurement exercise may
21 be different. The committees reviewing them
22 would be maybe have different standards for

1 the measurement level, the scientific
2 acceptability criterion and I think that is
3 all I should say because I am getting into
4 territory where I --
5 MS. PAGET: So I guess I agree
6 with what I am hearing completely that not to
7 get hung up and I certainly don't have the
8 knowledge in which to kind of form an opinion.
9 But I do have to say that there are some
10 things about the Geppert paper that are
11 appealing to me. And one is the role in the
12 weighting of process versus outcome and the
13 whole concept of signaling that effort that
14 could be much more in tune to the necessary
15 versus unnecessary care and treatment.
16 And maybe I am reading too much
17 into it but I guess my question about that
18 conceptually is does that open up -- does that
19 kind of thinking open up an opportunity for
20 NQF to actually be endorsing more measures
21 that are outcome-driven because it has a means
22 by which you can balance these two process and

1 outcome? I know that I hear repeatedly the
2 movement toward more outcome-based measures
3 and I just, when I read this conceptually it
4 feels to me as though there are some themes in
5 here that might be important for us to
6 reiterate in a guidance or whatever product
7 that comes out of here. And that is one that
8 to me feels like it could be conducive to
9 where NQF is hoping to go.
10 DR. ROMANO: Yes, so I think what
11 we are hearing -- if I am not summarizing
12 correctly please stop me. But I think what I
13 am hearing is that we don't find this two-part
14 conceptual model terribly useful. I mean
15 fundamentally at the end of the day, the
16 purpose of this exercise, the reason we are
17 here is to provide better guidance to measure
18 developers and to steering committees to help
19 them submit composites and to help them
20 evaluate composites.
21 And so from that perspective, we
22 don't -- we want people to use measurement

1 science. We want people to use the
2 appropriate tools from the armamentarium of
3 measurement science but we don't know
4 necessarily want people to -- we don't want to
5 force people into a particular bin here based
6 on this conceptual model because this may be
7 an over simplification. This may be to some
8 extent a false dichotomy. Am I correctly
9 capturing what people are thinking?
10 DR. ZASLAVSKY: I agree with that
11 as far as it goes but I think we shouldn't
12 underestimate the importance of having a
13 conceptual orientation in developing
14 something. And the concepts that underlie
15 that dichotomy are useful concepts and could
16 make a real difference.
17 You might end up with several
18 composites where there is a really clear
19 conceptual argument for using one of them for
20 public reporting and for using another of them
21 for pay-for-performance and another one for
22 internal process improvement.

1 And so asking people to make that
2 part of their submission, you know to be very
3 practical about it, not with a view just to
4 putting things in a bin but to giving the
5 reasons why, the way this was constructed
6 makes it particularly good for particular
7 purposes I think really should be part of the
8 exercise of evaluating the composite.
9 DR. ROMANO: Thank you, Alan, that
10 is perfect.
11 DR. KAPLAN: Well I agree because
12 I think that if -- but maybe what is needed is
13 give people some examples and some guidance.
14 For example, if you are trying to estimate
15 patients' experience with the doctor's
16 communication, here is an approach that
17 includes internal consistency reliability
18 because I have a set of things that I am
19 trying to measure, all of which I think
20 measures a patient's experience of a doctor's
21 ability to communicate with them.
22 If I am trying to measure diabetes

1 outcomes and I am trying to estimate
2 physician's performance with those measures,
3 here is what I need to look at. I need to
4 make sure that if I am using it for physician
5 performance, there is a physician thumbprint
6 that I can show you that there is some --
7 doctors behave consistently and they differ
8 from each other. So that is an example of
9 that kind of evaluation.
10 If on the other hand I am trying
11 to get risk adjuster for the total illness
12 burden index, then is a patient with
13 gastroenterologic problems likely to have
14 cardiovascular problems, likely to have
15 difficulties with joint disease. Probably
16 not. So internal consistency reliability in
17 that case wouldn't make any sense. So how am
18 I going to tell if there is consistency across
19 the things I am measuring in sort of a review
20 of systems perspective, so I can get a
21 composite measure that makes sense to me that
22 estimates a patient's complex -- the totality

1 of a patient's complex comorbidities?
2 So you might want to cluster these
3 things or American Board of Internal Medicine
4 has no trouble with cognitive performance of
5 physicians. They use it to accredit
6 physicians. So if you have got a different
7 kind of performance measure under the
8 microscope, that has a different set of more
9 like a cognitive performance psychometric
10 approach. Maybe some examples by category of
11 things, whether it is -- and those kinds of
12 things might help people who are submitting
13 measures look at what you are asking them to
14 do.
15 DR. ROMANO: What makes it easiest
16 I think for NQF staff and steering committees
17 is if it is a menu. So you choose. You have
18 composite type A. Then you submit A1, A2, A3,
19 and that leads to this decision. If you
20 choose B, then you submit B1, B2, and B3. But
21 I think what we are saying is it is not that
22 simple.

1 DR. DE LONG: I was just going to
2 ask what are A and B.
3 DR. ROMANO: Well I mean A and B
4 would be hypothetically Model 1 and Model 2
5 here. But I think what we are saying
6 collectively is that it is not that simple.
7 That it does need to be sort of written out.
8 What is the concept that we are trying to
9 measure? And what is the aim of that
10 measurement? And then what are the
11 appropriate tools for evaluating whether the
12 measure is accomplishing those aims. Is that
13 --
14 DR. KAPLAN: Yes, from the measure
15 developers' approach.
16 DR. DE LONG: But I understood you
17 to have different concepts, rather than
18 conceptual model one and conceptual model two,
19 that you listed three I think. And I thought
20 we were going down the road of maybe there are
21 different buckets that we could elucidate and
22 then start with A1, A2, and A3 in terms of

1 what the requirements are. Is that not -- did
2 I misunderstand you?
3 DR. KAPLAN: Well I think what I
4 was trying to say is there are different
5 approaches you would use to reliability for
6 one purpose or for one construct maybe and
7 there are different approaches you would use
8 for another. So if you gave examples, so if
9 you have what is the measurement today -- what
10 are you trying to measure? How do you know if
11 you are doing that consistently across a
12 composite? What evidentiary approach are you
13 going to use? And then for the validity side,
14 are you going to be accurate? But it is going
15 to vary by what are you trying to measure?
16 DR. ROMANO: Can we predefine all
17 the relevant buckets or is that a task that
18 fundamentally has to be left to future
19 discussion in future steering committees?
20 DR. KAPLAN: Well I don't want to
21 dominate this conversation but I think that
22 you could probably give examples that would

1 elucidate that. For most people who are going
2 to come in with measures, you are not going to
3 be people who aren't at least some kind of
4 cogency with respect to measurement aren't
5 going to come in with measures to begin with.
6 So if you give them examples, here is the
7 kinds of approaches one could use in
8 estimating physician performance, in
9 estimating hospital performance, in estimating
10 this class of variables like if I am going to
11 add up all more mortality for the hospital,
12 what evidence is there that that is a measure
13 of the hospital's performance and is it
14 consistent across all subcategories of related
15 mortalities that you are trying to evaluate?
16 So I don't think you can do it in
17 a here is the Betty Crocker formula and you
18 are going to come out with a cake. You could
19 come out with a can of dog food.
20 And you don't want to end up
21 giving people -- being so rigid that you
22 really stifle because I think Alan is right.

1 In this case we are at an interesting sort of
2 stage of the development in the clinical arena
3 of creating these composites and everybody is
4 all edged up about it. So I think if you
5 tried to be rigid about it at this juncture,
6 you would probably even stifle creativity. I
7 don't think it is a good idea yet to kind of
8 really lock people into one approach. If you
9 don't shove a chrome box alpha in there,
10 everybody's head is going to explode. I don't
11 think that is going to -- that is even
12 rational.
13 DR. SHAHIAN: No. There is a very
14 wide spectrum, however. I mean they are
15 trying to combine all risk-adjusted mortality
16 rates or determining physician reliability and
17 a thumbprint of a physician or a physician
18 group is on one end of the spectrum.
19 Getting the X elements of a
20 central line bundle or a ventilator bundle,
21 which makes no pretense whatsoever of having
22 any empirical basis whatsoever is at the other

1 far end and we are trying to encompass all
2 those within something we call a composite
3 framework. And I am wondering if the latter
4 really even belongs in this evaluation
5 framework.
6 DR. ROMANO: Well that is our next
7 topic for discussion.
8 DR. GOLDSTEIN: Yes, I guess
9 thinking about this, and I keep thinking about
10 the composites we use in my division, so we
11 have the CAHPS ones which are pretty straight-
12 forward. It is doctor communication or access
13 or things like that. But we also use
14 composites and we have never submitted this to
15 NQF so I'm trying to think how it fits in
16 there.
17 For example, for Medicare
18 Advantage we have an overall rating that
19 combines 50 different measures, some
20 individual ones, maybe NQF-endorsed, some not
21 and there are lots of judgments we have made
22 along the way with weighting of measures and

1 how we do the calculations and all of that.
2 So I was kind of struggling listening to this
3 how compositing differs a lot for what we do
4 on our surveys is very different when we are
5 coming up to evaluate a provider and coming up
6 with this overall rating to say this is a high
7 quality provider.
8 I'm trying to figure out how that
9 all fits together. And when you get
10 submissions, you are going to get at that wide
11 spectrum. And what you may do for a survey is
12 going to differ from what you may do for a
13 clinical measure.
14 I remember early on for the
15 composite forms for NQF, and I can't remember
16 if it was a home health survey or one of them,
17 we just struggled filling it out because it
18 was really made for a clinical measure and not
19 a survey measure. And I think it changed over
20 time. But you may need to think of different
21 things for different types of measures,
22 whether it is survey, whether it is process-

1 type measures, or whether you are measuring
2 kind of at that broad level of the quality and
3 performance.
4 DR. CHASE: I like this discussion
5 coming in here again because I was trying to
6 get to I think when you put together a
7 composite again you should have to say what
8 was your thinking about how this gets to be
9 used.
10 And so I take our example with
11 diabetes. It was an interesting one because
12 you have to put that in the context of the
13 reason why we did that composite originally
14 was because when you looked in the gaps in the
15 community, it was completeness of care. You
16 could see there were these five things that
17 were in the guideline and over here they did
18 these three well and over here they did these
19 three well. And there wasn't any rhyme or
20 reason of how that happened, other than just
21 sort of practice how it had rolled forward.
22 So that became the reason why an

1 all-or-nothing made sense to bring those
2 together. It wasn't about now people argue
3 against it around well it doesn't really
4 reflect reducing risk in patients. You know
5 when you do all-or-nothing, it doesn't help
6 you when a patient is at 7.1 for an A1c
7 compared to somebody at 9.0. You get the same
8 credit to bring both of them down to 7.0, so
9 it is no good. And they say well that is a
10 different measure. You can do a different
11 composite that would be about risk reduction
12 and then it would need a different kind of
13 testing because then how you construct a risk
14 reduction measure is going to have different
15 reliability than an all-or-nothing.
16 So I wanted to tell that one
17 because once I go through and say that is a
18 really important thing, then I think there is
19 another kind of measure that people are going
20 to bring to NQF, which was to the earlier
21 point about people are feeling like there is
22 way too many measures out there and it is too

1 hard for consumers to understand. So I am
2 trying to get back to your point which is
3 people are going to come and say well we want
4 to do a composite prevention measure because
5 it is silly to give people 12 different
6 individual components and all they are trying
7 to do is make it simpler for people to see how
8 much prevention there is.
9 So is that good enough? Do we get
10 to where we say we need a construct but at the
11 end of the day one construct may just be
12 because it makes it easier to use and are we
13 okay with that or is that -- and maybe there
14 is some science around what is acceptable in
15 making it easier to use by just glomming some
16 things together.
17 So I am just curious what people
18 think about. If we are going to set this up,
19 are we really giving any differentiation
20 criteria for a review panel?
21 DR. DE LONG: I wasn't going to
22 posit an answer to that but I am curious about

1 your distinction between quality of care and
2 risk reduction. Maybe a naive question, I'm
3 not sure I understand. I would think the
4 purpose would be risk reduction. And your
5 quality of care should be totally in sync with
6 risk reduction.
7 DR. CHASE: Yes, they both are
8 dealing with risk reduction but I am saying
9 you could construct them in two different ways
10 for a different purpose. If you are trying to
11 show patients this is what you need to
12 completeness of care, you don't really care
13 that the doctor is good at it with 90 percent
14 of the patients. You want to know about it
15 for yourself and again, if that was it, as
16 opposed to this issue around now maybe we have
17 a different goal in the community around -- we
18 have pretty much got people accepting here is
19 the guideline and trying to implement it
20 consistently across the population. Now the
21 effort is let's be as efficient with resources
22 as possible. We are trying to get to what for

1 the given effort how much risk are we reducing
2 in a population?
3 So that is why I thought it was
4 really important to when you are bringing a
5 composite measure forward you should be
6 talking about -- you should have to articulate
7 why the measure is being -- why it is a
8 composite as opposed to the individual
9 components.
10 DR. BURSTIN: Just to follow up on
11 Jim's point and I think also to touch on what
12 Liz was saying, as well, we have heard
13 interest, for example, from CMS of saying can
14 you take a whole bucket of all these measures
15 that live on Hospital Compare that are cardiac
16 or a whole bucket of these measures that live
17 on Hospital Compare about something else and
18 just create composites? Would that be easier?
19 And so at the end of the day, even
20 if we get away from these conceptual models,
21 I still think it would be helpful, I think to
22 Jim's point of at least seeing if measures

1 came forward that took all 50 and said we have
2 taken all 50 because it is what we have got an
3 we think it is a pretty comprehensive view of
4 cardiovascular care and hospitals. What would
5 be required, other than saying we took the 50
6 we had in hand and here it is?
7 And so again, I am still struck by
8 Patrick's earlier point about this being a
9 spectrum. And I almost wonder for the
10 afternoon if it might be, if it doesn't take
11 us too far off base almost useful to kind of
12 almost create the anchors on the sides of the
13 spectrum and see if there might in fact be
14 different kinds of questions to at least give
15 a sense to developers of what would be
16 required to put forward. If you are bringing
17 a measure forward that truly is the 50
18 measures I have already got in hand in a given
19 topic area, what kind of additional analysis
20 is required for the construct to say it is an
21 acceptable composite versus the detailed
22 analytics David did to create the CABG

1 composite, which I think is probably the other
2 anchor or the CAHPS composite. It might just
3 be something to think about.
4 DR. KAPLAN: The only problem with
5 that Helen is you end up sometimes adding up
6 apples and airplanes and you can't. It has to
7 be driven at the base by some construct that
8 is clinically and from the -- it is not just,
9 those of us in the measurement science arena
10 can do a lot with the empirical stuff. But at
11 base it has to be driven by the people who are
12 -- what is it you are trying to measure? And
13 that is always definitional. That comes from
14 in this case it is probably the clinical and
15 the health services community. What are you
16 trying to measure? And then are these a good
17 reflection of it? Because you can add up
18 anything. But then the question is does that
19 make any sense to anybody or are you adding up
20 thing that are very, very different and very,
21 very divergent and although you can certainly
22 add them up and create an index. It makes

1 absolutely no sense to anybody.
2 DR. GOLDSTEIN: I guess I was just
3 going to add to, and I don't know how this
4 fits in the NQF process, NQF process tends to
5 be kind of a long process. So if I think of
6 our like our health plan program, we
7 reevaluate every single year the measures
8 included in our roll-up. So if we have
9 measures that are topped out, they go off,
10 quickly off. And plans don't like that
11 because they say oh, we improved in that
12 measure. That is a measure we are doing well
13 on and you see a mess and took it off. But we
14 are reevaluating and we keep adding new
15 measures to it in areas where we think we are
16 missing measures. So it is a really a dynamic
17 process and when the data goes live in October
18 each year, as late as August we may make a
19 call. This measure, one of our 50-something
20 measures there is an issue with it this year
21 and that will come off of it.
22 So it is a very, very, for that at

1 least, a very dynamic process. And when you
2 think of the NQF process, it works very well
3 for like the CAHPS measures or measures like
4 that that don't change basically year to year,
5 although there are differences and reliability
6 and things year to year that we look at for
7 the CAHPS measures and we make a decision to
8 take. We have, I guess one good example from
9 our CAHPS prescription drug plan survey that
10 we are seeing now. You know, very little
11 differentiation across plans. So we are going
12 to actually remove it from our rating system.
13 But how in this process are things
14 reevaluated really quickly and have more
15 dynamic process with NQF?
16 DR. BURSTIN: I don't want to get
17 us off track but we do have a process for
18 annual updates, as well as ad hoc reviews
19 anytime a measure changes. We are doing one
20 on Monday actually. So that is part of our
21 process. We have tried to be more nimble.
22 To me what it really speaks to is,

1 I think, this issue of we have lots of
2 discussions with CMS over the years is this
3 idea of are composites more conceptual frames
4 of which you pop things in and out or are they
5 actually grounded measures? And I think we
6 have had this debate at times saying it is
7 very hard for those being measured to say it
8 is a conceptual thing, we will pop things in
9 and out. And yet I understand that the
10 reality of administering a program is things
11 do sometimes change. It is an interesting
12 issue. I'm not sure it is specific to this
13 committee but it is one we have heard a lot
14 about. Well can't I just say I am using
15 endorsed measures and I am creating a
16 composite really essentially what the STARS
17 programs has done without bringing those
18 measures forward to NQF.
19 DR. ROMANO: Yes, I think it is an
20 important question. I mean ultimately at the
21 end of the day it is a choice of CMS or others
22 that are in this space as far as whether to

1 bring their composite to NQF for endorsement.
2 So CMS, others are free to
3 construct a composite and not bring it NQF for
4 endorsement. By bringing it to NQF for
5 endorsement, I think that there is an
6 implication that they are prepared to defend
7 it, that they are prepared to say that it is
8 based on a concept that they can defend, not
9 just because the individual measures are
10 useful but because the overall measure, the
11 composite measure has properties that make it
12 useful to decision makers.
13 So what I am hearing in general is
14 the sense that what we want going forward is
15 for measure developers to present a very
16 clear, articulation of what their measurement
17 concept is and how they designed their
18 composite to operationalize that concept and
19 related to that, how they intend people to use
20 it, how they intend it to inform the
21 audiences, decision-making or whatever.
22 And this is honestly this where I

1 am kind of with Liz in terms of saying well
2 isn't it all about risk. So this argument
3 maybe should be in steering committees. You
4 know you, others would have to defend your
5 concept and say well we think this is a useful
6 concept. And others would say well why is
7 that a useful concept? Because it all comes
8 down to patient outcomes. And if we are not
9 about reducing risk and improving outcomes,
10 why are we doing this at all? And then you
11 would come back with a counter argument. So
12 that argument can take place in steering
13 committees but probably we can't forestall
14 those arguments here.
15 I think that is what I am hearing
16 is we just want clear articulation of these
17 issues. Is that right?
18 DR. CHASE: So I just want to test
19 that because I would agree. But when a non-
20 composite measure comes forward are we putting
21 a new standard on there beyond the composite
22 itself? Because it sounded like you were

1 saying you have got to bring your theory of
2 how it would be used, which I would agree
3 with, but do you have to do the same thing if
4 you are bringing forward a single dimension
5 measure? And I think the answer is yes.
6 DR. BURSTIN: Yes.
7 DR. CHASE: And so all we are
8 adding in this is saying you have to do the
9 same thing in around why it is being
10 composited, as opposed to just again the
11 individual components that you can bring.
12 DR. ROMANO: And how it is being
13 composited because it may influence the
14 weighting methods that you use.
15 DR. SHAHIAN: But to Helen's
16 hypothetical 50 measures that we use and I
17 would just like to roll them up into one, is
18 it sufficient simply for one to articulate
19 that vision of their composite or do we
20 challenge the empirical basis of doing that,
21 as Sherrie has suggested?
22 I am not sure it is sufficient in

1 my mind simply to have the developer
2 articulate that that was what their vision
3 was. Otherwise, this becomes a free for all.
4 DR. DE LONG: I absolutely agree.
5 I am so much less interested in how they
6 developed it as how it works. And it seems to
7 me there has to be evidence that it is doing
8 what it was intended to do. And if you just
9 mash together a bunch of outcomes or processes
10 and they are actually shown to be effective,
11 it doesn't really matter what your perspective
12 was going into this, I think.
13 DR. SHAHIAN: And vice-versa.
14 DR. DE LONG: But you have to have
15 good evidence that they are valid. And we now
16 have some benchmarks to test against because
17 we have different types of measures.
18 For example if you bring forth
19 something developed using item response theory
20 and whatever and you test it against itself in
21 a split sample, you test it against some of
22 the other types of weighting so to speak, all-

1 or-none or whatever and it holds up, you have
2 brought forth evidence, it doesn't really
3 matter that you used item response theory
4 versus hierarchical modeling.
5 DR. KAPLAN: I think you need both
6 things and here is why. I think you need both
7 perspectives and the reason is suppose I had
8 the two trains left Chicago and a bunch of
9 questions like that. And so they were all
10 consistent and everything was great, except I
11 wrote them in French. And so what I really
12 was measuring was your ability to understand
13 French.
14 So yes, you can create composites
15 out of stuff but you will end up with Helen's
16 problem of adding up apples and airplanes
17 unless you have some expert-defined conceptual
18 approach that this is measuring X. And I
19 think it is measuring X. And then you have to
20 test it and make sure it meets the measurement
21 science standards of performance but you
22 bloody well better have a first idea that you

1 weren't measuring French instead of algebra.

2 So you have got to have that

3 undercurrent of understanding conceptual

4 grounding. And I learned this the hard way in

5 clinical circles, you had better be able to

6 defend that this measures diabetes care and

7 not patient sloth or something else that is

8 undercurrent. Maybe I attracted a bunch of

9 patients who are really, really couch potatoes

10 and lazy and yes, okay, it was my job to get

11 them to exercise but I can't come home and be

12 their personal trainer.

13 So you have to have measures of

14 what you are actually trying to measure,

15 physician performance, hospital performance,

16 whatever, grounded in some kind of conceptual

17 base.

18 DR. ROMANO: So I think in

19 response to David's, I think the solution here

20 is not lowering the bar. I'm not saying that

21 a developer can say anything but saying

22 basically that the developer has to articulate

1 the measurement concept and then show
2 empirically how what they have done is
3 consistent with that measurement concept.
4 And so that implies then the
5 Steering Committee can have two separate
6 discussions; one, if they like the measurement
7 concept, one if they accept the empirical
8 evidence, which might be different.
9 And so if I have been in the
10 meeting with Jim, Liz and I would have argued
11 against his conceptual framework but we might
12 have perfectly accepted the empirical evidence
13 but fundamentally those are two separate
14 discussions. Is that fair? But both of them
15 need to happen.
16 DR. ZASLAVSKY: I suggest that
17 maybe the action item here is to commission
18 the paper that organizes it in a kind of
19 simple way some of these different kinds of
20 rationales and conceptual bases for and give
21 some examples, as Sherrie says so that people
22 -- is it not going to be a dropdown menu. Not

1 in our lifetimes and hopefully never. But
2 there are a number of useful concepts that are
3 rationales for putting things together in
4 particular ways and doing certain kinds of
5 analysis. And people can be encouraged to use
6 one or maybe more than one would be better
7 because if something can be justified on more
8 than one basis or evaluated on more than one
9 basis, you have a strong evidence base and
10 this would be something that people submitting
11 these would be asked to refer to in developing
12 their own short statement of conceptual basis
13 and intended use of their measure.
14 DR. ROMANO: I like that idea. I
15 mean there is some previous work that we can
16 draw on, both I know Sherrie wrote a previous
17 paper I think for NQF. You have written some
18 work. So I think there are some elements that
19 potentially we could borrow from. And
20 obviously NQF staff will have to make a
21 decision about the commissioning per se.
22 Do people generally agree with

1 that recommendation?

2 MS. PAGET: I like that idea as

3 well but I guess I think this is the place for

4 this comment and maybe it is editorial and

5 maybe it is more than that. But somehow it

6 would be really advantageous if we could, and

7 I think this is in our jurisdiction also help

8 define for these measure developers, when you

9 use terminology such as optimal and your data

10 source doesn't include the patient, I don't

11 know if it is optimal or not. So optimal or

12 universal or any of this kind of terminology

13 that implies that boy you hit that composite

14 and you are golden and yet no one is deriving

15 systematically any information from the

16 patient him or herself. Somehow I would like

17 to be able to embed that into some of these

18 principles that we are talking about.

19 DR. ROMANO: Yes, okay so let's

20 put that on parking lot. There may be more

21 terms that we want definitions around. So

22 when people use the term optimal or when

1 people use the term -- there are other terms
2 that we have seen. Maybe we ought to have
3 more definitions so let's put that on the
4 parking lot.
5 Before we take a break -- oh, I'm
6 sorry. Was there another?
7 Oh, before we take a break I would
8 like to see if we can get some discussion or
9 some agreement about these other conceptual
10 models that Karen and her team has summarized
11 here. And I think that the concept here is
12 that although we don't necessarily have to
13 have specific bins within composites, we do
14 have to have a process where people declare
15 whether they have a composite or not. So that
16 we can't avoid. So because NQF has to have a
17 separate forum. They have to have a separate
18 process for evaluating composites.
19 So there is a need, I think, to be
20 clear about what actually represents a
21 composite and what doesn't. And as Karen has
22 suggested, there has been some inconsistently

1 in previous NQF processes about that.

2 So let's see if we could -- so the

3 specific terminology that NQF has used is that

4 a composite is a combination of two or more

5 individual performance measures in a single

6 measure that results in a single score. So

7 going to table three for example, one

8 implication of this we think is that when you

9 have a "composite" that is actually conceived

10 of as a single measure that is based on

11 multiple items, that would not be considered

12 a composite from the standpoint of NQF review.

13 In other words, that is just saying that in

14 order to assess this concept, you need to ask

15 seven questions, seven items. And each of

16 those items is not a performance measure in

17 itself. Those are just the components of a

18 single measure. A measure of communication,

19 a measure of timeliness, whatever it is.

20 So that would, I think exclude

21 many of the CAHPS-based composites, wouldn't

22 it, that have actually been reviewed as

1 composites?

2 So what do you people think about

3 that? Do people see that? Because again the

4 idea here is that NQF is treating a composite

5 in a little different way maybe than what

6 psychometricians do which is that a composite

7 is a composite of measures, not a composite of

8 survey items.

9 DR. BIRKMEYER: Can I see if I

10 understand the distinction that you are trying

11 to draw? Because I am not sure that I do.

12 Are you saying that an instrument

13 that has multiple items that are trying to

14 measure one thing at the patient level, that

15 we know is not a composite measure. But

16 things that are rolling up measures of

17 performance at the provider level, those would

18 be.

19 So is this just a patient level

20 versus higher level distinction that you are

21 trying to make or is it subtler than that?

22 DR. ROMANO: No. No, no. I don't

1 think it is subtler. It is just different.
2 I think if you have, for example,
3 and again I am going to defer to the CAHPS
4 experts, but if you have a number of items
5 that are necessary to create a reliable
6 measure of physician-patient communication,
7 that is a single measure of physician-patient
8 communication that is built on a set of items.
9 But if you then say that I am going to create
10 a composite measure of patient experience with
11 physicians or patient experience with
12 hospitals that rolls up five different aspects
13 of the patient's experience with the hospital,
14 that becomes a composite that NQF reviews
15 differently as a composite because it is built
16 on five different measurements.
17 DR. BIRKMEYER: This is a question
18 are the measures rolling up to one domain of
19 performance or multiple domains?
20 DR. DE LONG: That's not how I see
21 it, actually. I see it as you could have an
22 instrument that is for the purposes of

1 assessing patient-doctor communication. You
2 could also apply a question to a doctor. That
3 is the same domain. How do you communicate
4 with your patients? How much time do you
5 spend with them and whatever? That is in the
6 same domain. It is measuring the same thing
7 but it is not -- it is a different item, a
8 different measure.

9 The other one was a survey that
10 you asked and it had 36 items and the patient
11 filled out all 36, we hope. That is an
12 instrument that has its own measurement
13 properties. You could roll up those two as a
14 composite. They are in the same domain but
15 they are not the same thing. But we are
16 considering all the questions in the survey as
17 in one bucket as the outcome of that survey is
18 the measure.

19 DR. ROMANO: I mean just -- oh,
20 Helen wants to speak. But just to give a
21 specific example.

22 So in measuring blood pressure for

1 example we commonly say that people need to
2 take two or three blood pressures measurements
3 and average those. So conceptually, that is
4 the same thing as asking two or three items on
5 a particular domain and saying that we have to
6 use that in order to construct a reliable
7 measure of a single clinical concept.
8 DR. BURSTIN: Well let me just
9 follow on the CAHPS example because that is
10 actually one we have thought a lot about and
11 Liz and Alan and others can weigh in here.
12 So for example we don't endorse
13 the CAHPS survey. Very clear. Lots of items
14 in the individual CAHPS survey. We don't
15 endorse the CAHPS survey or the items within
16 it. We do endorse the score based -- a
17 performance measure based on the use of the
18 CAHPS instrument.
19 The question is, if the CAHPS
20 performance measure includes five domains that
21 are separately reported out and publicly
22 reported as separate domains, is that really

1 any different than individual measures, if
2 each of those components becomes essentially
3 a measure to be publicly reported? Is that in
4 some ways a composite performance measure?
5 DR. ROMANO: That is what we are
6 saying. Under this framework, this would be
7 viewed as an individual measure and not
8 treated as a composite measure.
9 DR. BURSTIN: The CAHPS? A CAHPS
10 performance measure would be an individual
11 measure rather than a composite, even if it
12 has individual components to be publicly
13 reported?
14 DR. ROMANO: Oh, no. It is when
15 you are rolling up the five domains that it
16 becomes a composite. The individual domains
17 are not composites.
18 DR. BURSTIN: Yes.
19 DR. KAPLAN: Okay, now I am really
20 lost.
21 So back to sort of where I am
22 trying to kind of get my arms around this.

1 There are things we call higher order
2 constructs like mass that each have -- I am
3 trying to kind of -- Shelly hates it when I do
4 the math example, but my husband is a
5 physician so he likes sort of more clinical
6 examples. But math is a good one because it
7 has algebra. It has all of these components
8 we are all familiar with. But if I used a
9 single item to estimate any one of those
10 individual things, you would be very unhappy.
11 And if I published that single item like
12 algebra with one question, you would be really
13 unhappy.
14 Those are also complex constructs.
15 They need multiple items. So just like CAHPS
16 has patients' experience with doctor
17 communication, did you like the front office?
18 The facilities, were they clean or dirty,
19 blah, blah, blah.
20 Now I am going to create a higher
21 order construct and wind those all up into a
22 score.

1 So we have got these complex
2 constructs and then we have higher order
3 constructs. Supposing you wanted to measure
4 obesity. I can use, by the way, also a
5 composite, the body mass index. Then I can
6 add truncal obesity. Then I can add whatever
7 water displacement super-duper thing I have at
8 my hands. Then I can add something else.
9 Your reports about whether or not you gained
10 a belt size in the last six months or a dress
11 size in the last six months.
12 I can add all those things up and
13 I am creating a higher order construct called
14 obesity. So I think we are getting caught up
15 in this composite business. Anything that you
16 use more than one thing to estimate, in my
17 view, is a composite. And what you do with
18 that afterwards and what you are trying to
19 represent become the construct you are
20 actually trying to represent. And as that
21 moves further and further away from and gets
22 larger and larger and much more

1 multidimensional, that is when you get these
2 higher order things that have all of this
3 interior that could be separately reported but
4 also needs to be evaluated to the extent it
5 represents this higher order construct.
6 DR. ZASLAVSKY: I'm not sure there
7 is an entirely principle of answers to that,
8 the question that you asked Patrick in that if
9 someone came in with an SF-12 and said that we
10 wanted to report this out, you are probably
11 not going to start over and form a committee
12 to examine whether that is an adequate
13 construct, even though it is a composite.
14 The CAHPS items, there are certain
15 groups of CAHPS items that have been used for
16 12 years. You are probably not going to spend
17 a lot of time on that but if someone came in
18 with another version of the CAHPS survey, of
19 which we are working on about five of them
20 right now, and had another set of items that
21 were put together as a single construct, you
22 probably would look at that.

1 So it is really, I think, more a
2 question of the history and the existing
3 evidence base of former scrutiny, rather than
4 any real difference in principle between what
5 you are looking at in those different
6 situations.
7 DR. ROMANO: Yes, I think what --
8 I am really trying to help NQF here. And so
9 from the NQF perspective, NQF is about
10 performance measures, not items, measures that
11 are used to say something about provider or
12 plan performance that are used to drive the
13 market, that are used for public reporting,
14 that are used for accountability and so forth.
15 And so you may call those things
16 composites just because they have five items
17 that are all algebra questions. And of course
18 it is obvious that you can't say anything
19 about people's ability to do algebra without
20 asking them at least five questions. You may
21 call that a composite but from the NQF
22 perspective, that is not a composite. That is

1 just that you need five questions to address
2 this single concept.
3 What makes it a composite from
4 NQF's perspective is that you are taking
5 multiple measures that are performance
6 measures that are separately reported as
7 performance measures that say something about
8 different domains of performance and you are
9 rolling them up into a higher order, if you
10 will, a higher order composite that addresses
11 a larger concept. Is that helpful?
12 DR. DE LONG: So can we have
13 clarification? You indicated that the SF-12
14 in your terminology is a composite. My
15 understanding, according to what you are
16 saying, is that it is a measure that has 12
17 items.
18 DR. ZASLAVSKY: Well let's take
19 two really clear cut examples. If you do your
20 three blood pressure reading was your blood
21 pressure while doing jumping jacks, your blood
22 pressure while lying on the table and the

1 blood pressure while eating lunch, those would
2 be three different measures that you composite
3 in a particular way.
4 If it is just taking three
5 randomly chosen algebra questions or three
6 measures just at randomly chosen times under
7 the same circumstances, then that is not a
8 composite. That is just replication of the
9 same measurement.
10 But if you look at the CAHPS, like
11 the CAHPS getting care quickly scale, asks
12 about getting care quickly when you need an
13 urgent visit and getting care quickly for a
14 routine visit, you know, getting appointments
15 for a routine visit. Those are different
16 things. The decision to put those things
17 together is based on a conceptual model of
18 their content, mainly of their content-
19 relatedness, although to some extent, based on
20 psychometric evaluation as well.
21 And so somewhere someone had to
22 look at that and make a judgment about that.

1 Once that is done, you are not going to
2 revisit that every time you use that measure
3 and you may, for future purposes, think of
4 that as being one measure when you think about
5 going up to a higher level super composite.
6 But there was a process initially
7 of treating that as a composite because it
8 wasn't really three different items. The SF-
9 12, you know, I don't know there might be --
10 whether you are sad and blue or happy and
11 pink, or whatever the different items there,
12 and they are different questions. And there
13 was again some decision made about how you
14 form those together, which we don't revisit
15 every time we use it. But there was some kind
16 of a process, a lot of process that people
17 went through in order to get there.
18 DR. BURSTIN: Just one thing, and
19 I am not sure if it is helpful but this was a
20 major issue for us as part of this PRO work we
21 just did. And I can't tell you how long it
22 took for the committee to agree on what these

1 things are all called but let me just try this
2 because I think it was helpful.
3 So in the PRO context, the patient
4 reported outcome was the concept and we
5 actually used the Minnesota measure of
6 depression as a way to sort of explain this.
7 So PRO content is want to look at
8 depression. That is the concept, the PRO. We
9 then talked about the PROM. People talk about
10 patient-reported outcome measures. In that
11 case, it is the PHQ-9, which is a standardized
12 tool used to assess depression. To me, the
13 CAHPS is a standardized tool used to assess
14 patient experience of care.
15 We then tried to make a
16 distinction of a PRO-based performance
17 measure, a PRO-PM as we called it, which was
18 the performance measure based on use of the
19 tool.
20 I think what Patrick is trying to
21 say is we are not going to get into the issues
22 of the tool itself or the components of the

1 tool. We will get into it only insofar as it
2 relates to the use of the measure for
3 performance assessment. And I think that is
4 probably enough. And I don't think we need to
5 do too much more on this.
6 DR. DE LONG: But one of our
7 mandates here is to define a composite. And
8 I think we are still not there with respect to
9 whether the CAHPS survey is --
10 DR. BURSTIN: Wait a minute.
11 Maybe I am off but I feel like we are there.
12 DR. DE LONG: Okay.
13 DR. BURSTIN: I feel like we have
14 a reasonably good sense that the tool/survey
15 is not the performance measure. It is not
16 what NQF endorses. It is the substrate around
17 which people develop a performance measure.
18 We are only endorsing the performance measure.
19 So there may be complex concepts as part of
20 surveys. That is all well and good but when
21 it gets to NQF, we are talking about the
22 measure around it, rather than the survey or

1 the tool.
2 DR. ROMANO: So it is important, I
3 think, that we need to be clear throughout
4 that we are talking about composite
5 performance measures, not composite measures -
6 -
7 DR. BURSTIN: Correct.
8 Performance measures.
9 DR. ROMANO: -- but composite
10 performance measures.
11 DR. BURSTIN: Correct. Yes.
12 DR. CHASE: So I would agree with
13 this. I think we can be there with once there
14 is a standardized tool that is not a
15 composite. Because this is helpful because
16 when you are submitting something you want to
17 know if you have to check that box or not.
18 The one I think there were there
19 is another area of gray that you mentioned in
20 this, as I recall, is what about multiple sort
21 of measures of a particular thing? And I will
22 give the example of -- and let's not get into

1 the clinical stuff because I won't get that.
2 If we were saying LDL control, you
3 could construct a measure that says you either
4 your LDL was either below a certain level or
5 you were on a statin. Those are two things
6 and they are being combined. To me, that is
7 not a composite measure. That is two ways to
8 ask the same, to evaluate the same thing and
9 that might be helpful, too with some guidance
10 of when it is multiple pieces identifying
11 something, unless you are somehow constructing
12 it in a different way. When it is just
13 multiple yes/no to get to the same question,
14 that is not a composite.
15 DR. ROMANO: So you are talking
16 about sort of Boolean logic in general, where
17 there is a set of and statements or or
18 statements that are necessary --
19 DR. CHASE: Yes.
20 DR. ROMANO: -- for the
21 construction of the measure.
22 DR. CHASE: Right. Again, you can

1 take it to a far degree where we might say now
2 you really are a composite. Because again I
3 think these can morph into some gray areas.
4 But there are a lot of things that come
5 probably to measurement where there are
6 multiple things being assessed but they are
7 really still the same thing.
8 DR. BURSTIN: And this comes up
9 with us a lot, people submitting measures as
10 measure pairs. Always look at this measure
11 with this measure. And we struggled actually
12 about whether or not we should bring to you
13 the issues of pairing, tripling, and
14 quadrupling and we decided not to for your
15 sake and ours because it is a complex issue
16 but we don't believe those are composites
17 either.
18 DR. BIRKMEYER: Well then I don't
19 get the definition, then. And I appreciate
20 like how simple that example is. You know,
21 you have got a process measure that a person
22 is or isn't on a statin and you have got some

1 continuous measure of the LDL and you are
2 combining that around a construct of LDL
3 management.
4 And I don't understand -- and they
5 are measuring different things but it is under
6 the umbrella of a single construct and I don't
7 understand how given what the measure is of a
8 composite, why that is not a composite.
9 DR. BURSTIN: Because I think they
10 are not separate measures. I mean let me play
11 that out because actually that is a good
12 example.
13 We will sometimes see measures
14 come forward and again, depending on the data
15 source, they may say you can capture LDL
16 control in one of several ways. One way is to
17 actually be able to have the actual laboratory
18 data and say LDL is less than 100.
19 One other way may be and there is
20 pretty good evidence in the cardiovascular to
21 say statin alone is probably good enough.
22 So in some ways even irrespective

1 of the LDL level that you would actually
2 combine those constructs and say either of
3 those meets the numerator for this measure.
4 It is not as if they are two separate scores,
5 two separate measures combined into a single
6 score. There are different ways of
7 representing, I think the same concept. It is
8 fuzzy, John. I'm with you.
9 DR. ROMANO: But I think that it
10 is the same. It is the same thing that we
11 just talked about, which is that in order to
12 measure a single concept you have to look at
13 two different pieces of information. Another
14 example is very common in clinical studies to
15 assume that anybody who is on an
16 antidepressant as depression, even if their
17 PHQ-9 score is fine. So it is the same thing.
18 If you define depression as being on an
19 antidepressant or having a PHQ-9 score, you
20 have predefined that that is what is necessary
21 to define that concept. It is not compositing
22 two different performance measures. It is

1 saying that you need two different items of
2 information to address a single performance
3 concept.
4 DR. BIRKMEYER: I'm sure that I
5 will learn more but I still haven't quite
6 gotten to the point where this is anything
7 more than just a simpler version of the
8 advanced diabetes care instrument roll-up and
9 a much simpler version of the STS version
10 where you are taking like one measure of a
11 process of care and another version of an
12 outcome.
13 So but I will stop talking.
14 DR. ROMANO: Well I mean I think
15 we might or might not agree with that
16 particular example. I mean, I think Helen's
17 example may be clearer. So you may push back
18 on Jim's example and way well that is not a
19 good example of the phenomena.
20 DR. BIRKMEYER: Well I certainly
21 get kind of the multiple items within one
22 instrument that gets applied at the patient

1 level thing as like one measure and then gets
2 rolled up to a provider. That I get. And
3 that is what the opening document of NQF says
4 and I get that distinction. But this other
5 example to me feels like it is very different.
6 DR. KAPLAN: I'm worried and I
7 don't want to be responsible for delaying our
8 break here but I am worried that this is --
9 I'm lost, too. Because for me the data source
10 is irrelevant. If your survey -- I don't
11 care. If it is a multi-dimensional construct
12 and it comes from a survey, so what? It is
13 still a multi-dimensional construct. What I
14 thought Helen was originally saying was we are
15 treating those little multi-measure and don't
16 get lost on the item versus measure, every
17 single one of these things is a measure, it is
18 just collectively they measure a different
19 concept or a concept together.
20 But the problem that I am having
21 is you are really, I think, NQF is talking
22 about higher order constructs. For me, you

1 are starting to add up patient experience data
2 with hospital mortality data, with patient
3 safety data and now you have got a real mega-
4 construct about how good this hospital is. Do
5 I want to go there? Whatever that is, that is
6 a real mega-construct.
7 Now you have got higher order
8 constructs that are combining information from
9 various different sources and that we
10 shouldn't get lost on. They could all come
11 from the same data source but they measure
12 different things that collectively now measure
13 something larger.
14 And so if that is NQF's definition
15 of a composite, then strike the one that is in
16 the document now because that is confusing.
17 It confused me. Just adding up two or more
18 things, it depends on what you are trying to
19 represent.
20 And I think, Helen, what I
21 understand you guys trying to represent is
22 something larger than the patient experience

1 data or collectively or even taking all the
2 patient experience data collectively. It is
3 something higher order than these measures of
4 stuff that can be multi-item, multi-component.
5 But it is a real higher order construct that
6 you are talking about.
7 DR. BURSTIN: It is always higher
8 order. I think at times we have seen -- I
9 mean in the last year we had a cardiovascular
10 project. A series of measures came in for
11 patients who had implantable defibrillators.
12 They should be on this. They should be on
13 this. They should be on this. Cardiovascular
14 was like, this is nonsense. They should be on
15 all of those. Make it a composite. So ACC
16 took it back and made it a composite.
17 It is not necessarily something
18 higher -- again, I don't want to get hung up
19 on what is higher order to me versus higher
20 order to you. I just think the end of the day
21 the idea was those individual measures they
22 stood alone told very incomplete parts of the

1 picture and the cardiovascular committee was
2 left uncomfortable that anybody would use any
3 one of those measures in isolation and assess
4 the quality of care that that cardiological
5 service was providing for patients with ICDs.
6 DR. KAPLAN: Well let me come back
7 to them and ask a question. Supposing I have
8 a new measure of participatory decision-making
9 so it is not a new measure. But supposing now
10 I have -- I am trying to get a sense of
11 whether or not doctors include patients in
12 treatment decisions. And I have seven items
13 that measure that. They all come from a
14 survey. That is a composite measure but --
15 DR. BURSTIN: A composite
16 performance measure.
17 DR. KAPLAN: Okay, now I am still
18 stuck on -- and if I am lost, the odds are at
19 least 50-50 that somebody else will be lost.
20 DR. BURSTIN: I think it is
21 measure/tool -- I mean, people call those
22 things all kinds of things.

1 DR. KAPLAN: Well first of all I
2 like instrument because a tool is to dig and
3 shovel and an instrument is to make smaller
4 things with. But if you have got -- so then
5 you have to, I think, inform the field about
6 what you are meaning by performance assessment
7 composites and make the definition more
8 related to that. Because it is still
9 performance if the physician is being
10 evaluated on a set of skills if they come from
11 the patient, they come from the chart, they
12 come from here. They are still being
13 evaluated on a set of skills. If you don't
14 mean to include interpersonal care as that set
15 of skills, then that is an important
16 distinction to make.
17 DR. ROMANO: Well we are overdue
18 for a break. So I think we might have a
19 couple of offline conversations during the
20 break but everybody rejuvenate themselves on
21 coffee or whatever your preferred beverage is
22 and we will come back in ten minutes, I guess.

1 (Whereupon, the above-entitled
2 matter went off the record at 10:55 a.m. and
3 went back on the record at 11:13 a.m.)
4 DR. ROMANO: Well let's go ahead
5 and reconvene. Dale, are you still with us on
6 the phone?
7 DR. BRATZLER: Yes, I am.
8 DR. ROMANO: Wow. Thank you for
9 your patience.
10 DR. BRATZLER: I set aside the
11 whole day to be completely available.
12 DR. ROMANO: Okay. We can't read
13 your body language so just feel free to
14 interrupt as you deem appropriate and we will
15 respect that.
16 DR. BRATZLER: Yes. It was a very
17 fascinating discussion. I'm not sure I could
18 have added much.
19 DR. BURSTIN: Dale, this is Helen.
20 So I think we are going to talk a little bit
21 about all-or-none. You might want to give us
22 some of your insights from those measures you

1 guys were using in the QIOs as well.

2 DR. BRATZLER: Okay. So would you

3 like for me to go ahead at this point?

4 DR. BURSTIN: Not quite yet.

5 DR. ROMANO: Wait a second.

6 DR. BRATZLER: Yes, okay. All

7 right.

8 DR. ROMANO: So I think that the

9 bad news is that we have gotten through one

10 out of a whole list of questions.

11 (Laughter.)

12 DR. ROMANO: But the good news is

13 that that question is so big it has really

14 encompassed some of the other questions within

15 it. So we may have made more progress than we

16 think and we have certainly come to recognize

17 the complexity of this space.

18 I think one of the lessons that

19 came out of my offline discussions during the

20 break is that really the measurement science

21 tools that many members of this committee

22 bring to the enterprise that these tools need

1 to be brought into the discussion of all
2 measures, including measures that we may
3 describe as not being composite measures for
4 the purpose of this discussion. And this kind
5 of leads into some discussion of these Boolean
6 measures. And so I wanted to get those issues
7 on the table and then we will go into a little
8 bit more about this business of component
9 measures.
10 So we have had a number of
11 measures that have had Boolean logic, either
12 a series of, if you will, as Alan mentioned in
13 the break, serious reportable events where it
14 is a series of things that did the patient
15 have this, or this, or this, or this, A, or B,
16 or C, or D. It is a long list of
17 complications, typically.
18 Those are sometimes viewed as
19 composite measures. Sometimes they are viewed
20 simply as a single measure that may have
21 several different components.
22 Similarly, we have these all-or-

1 none composites that are based on the premise
2 that providers must do A and B and C and D and
3 E If they do all those things, they get
4 credit. If they don't do all those things,
5 they don't get credit.
6 And so the question is are these
7 scoring methods for composites or are these
8 different types of measures? Should these be
9 viewed -- and I think our discussion, your
10 chair's discussion with staff before suggested
11 that these types of measures should really be
12 viewed as single measures, where the
13 developers are coming to NQF and saying that
14 we think that in order to measure this
15 construct, it needs to be done with a series
16 of ten questions and it needs to be formulated
17 as A and B and C and D and E. And so the
18 notion then is that these are not separate
19 performance measures but these are ten items
20 that are necessary in order to tally a single
21 performance measure.
22 So is that a distinction without a

1 difference? Is that useful?
2 So with that construct then, all-
3 or-none scoring and any from a list would not
4 be considered composites for a separate review
5 process. They would go through the process
6 being considered as individual measures. Is
7 that -- am I summarizing that, Karen? So what
8 do people think?
9 DR. BRATZLER: Patrick?
10 DR. BIRKMEYER: I'm sorry. We
11 discussed this a little bit at the break. It
12 seems like we are trying to draw a dotted line
13 at like what altitude do you need to get to be
14 a composite lover. But at the end of the day,
15 does this matter only to the extent of like
16 which committee or group to these measures go
17 to or is it more important than that?
18 DR. BURSTIN: It is more
19 substantive in that it then leads to a whole
20 set of questions about whether we need to get
21 into a deep dive on the components within the
22 composites.

1 So this is one issue. If an all-
2 or-none is not considered a composite, then
3 how do we handle the components within them
4 and the efforts to harmonize with existing
5 measures?
6 DR. BIRKMEYER: But just to
7 follow-up, you know, if it went to the
8 composite evaluation process versus the
9 regular, would there be a different level of
10 scrutiny on the components that roll up into
11 whatever it is that is being measured to get
12 more slack of you go one way or the other?
13 DR. BURSTIN: According to our
14 criteria, yes. In that --
15 DR. BIRKMEYER: Which is more
16 stringent?
17 DR. BURSTIN: The composite
18 measure evaluation criteria would specifically
19 require that the component measures either be
20 evaluated to see if they are stand-alone
21 measures or at least meet criteria for
22 appropriateness within the composite, even if

1 not endorsed as stand-alones.

2 DR. BIRKMEYER: So if you had a

3 measure that could be demonstrative -- whose

4 validity and usefulness could be demonstrated

5 at the summary level but not at the component

6 level, then it would be one would

7 preferentially not want to go through the

8 composite evaluation process. Am I

9 understanding that right?

10 DR. BURSTIN: I actually never

11 thought of it that way before but I guess that

12 is one way to flip that on its head. I always

13 think of it in the other direction of saying

14 then you have to go look at the components as

15 opposed to the flip of not.

16 DR. BIRKMEYER: Because I would

17 have guessed just the opposite. I mean,

18 before I got into this process I would have

19 guessed just the opposite, that the whole

20 process of breaking out in evaluation process

21 for the composites is the focus on sort of the

22 measure characteristics at the summary level

1 and not at all of the little pieces.

2 We already have a process in place

3 that can evaluate all of the little pieces.

4 DR. BURSTIN: Should the little

5 pieces then be submitted separately?

6 DR. KAPLAN: I wasn't going to say

7 anything before lunch --

8 (Laughter.)

9 DR. KAPLAN: -- but now I am a

10 little bit -- I am even more lost. Because if

11 -- take the diabetes -- I hate to harp on

12 diabetes but it is an example I know the best.

13 If you were going to say and we just told the

14 National Association of Public Hospitals to

15 push back CMS on this very issue about the

16 all-or-none scoring for the diabetes measures

17 taken as a group. So if there are nine of

18 them, say, and I was going to create a

19 composite for institutional-level performance

20 and it was going to be an all-or-none, it

21 wouldn't go to the composite. You have to

22 have A and B and C and all the way to nine.

1 It wouldn't go through the composite process
2 but if I was going to say I am going to
3 evaluate how many of these you got and give
4 you a score however I do that, then it would
5 go through the composite process.
6 DR. BURSTIN: That is why we have
7 always treated all-or-nones or weighted
8 composites the same. And they do go through
9 the composite process.
10 DR. KAPLAN: All-or-none scoring
11 of it would still not be enough -- would be
12 enough -- wouldn't trip it into some separate
13 review process. It is still a composite?
14 DR. BURSTIN: In our current
15 parlance, it is still a composite and that is
16 a question for you. Is that reasonable?
17 But at the same time we do ask the
18 committees to go through -- we just went
19 through this. We have a colonoscopy quality
20 index that just came to NQF, was submitted on
21 a single form, all nine components or ten
22 components on a single form. The committee

1 had some concerns with two or three of the
2 components out of nine of being perhaps not as
3 evidence-based as they would prefer.
4 So at the end of the day, do they
5 thrown out the entire composite because two or
6 three of them they didn't think rose to the
7 level of the others? Should that have been
8 submitted on nine separate forms so that we
9 actually can take the deeper dive. Ultimately
10 we will end up re-reviewing the measure and
11 force the committee to go component by
12 component because otherwise we just couldn't
13 make sense of it.
14 DR. ROMANO: Well, okay. So let
15 me get radical here, which is so I am feeling
16 a lot of confusion and a lot of push back or
17 concern about sort of trying to draw this
18 bright line between what is a composite and
19 what is not a composite and what undergoes
20 composite review and what doesn't.
21 So maybe we should throw out this
22 whole distinction and just go back to measures

1 and we just have measures. And so if a
2 measure developer comes to NQF and says I have
3 a measure. It happens to roll up five other
4 measures but at the end of the day, it is
5 supposed to measure some concept. And that
6 measure can be evaluated using the appropriate
7 tools.
8 Is it conceptually -- I mean I
9 think this is getting to your point. Is it
10 conceptually different to have all or none
11 scoring versus some kind of weighted scoring,
12 to have a separate process for those two to be
13 evaluated? An easier process for one than the
14 other doesn't feel right. Is that what you
15 are getting at? It doesn't feel right.
16 DR. KAPLAN: Yes. To me, you have
17 got nine things that you are measuring and
18 your collectivizing them some way or the
19 other, the scoring is irrelevant. You are
20 still collectivizing them. If you turn them
21 and score them, if you all-or-none score them,
22 if you do mean scores, you are still pulling

1 together a set of things that measure what we
2 are going to call diabetes quality. And maybe
3 I don't even have enough of them for certain
4 levels of performance assessment or maybe I
5 can get away with fewer at other levels of
6 performance assessment but together they
7 measure diabetes quality. And that is what,
8 for me, represents a composite.
9 DR. CHASE: So I would agree. I
10 don't think it makes sense to just totally --
11 so all-or-nothing composites never have to
12 come through a process. But how they are
13 dealt with once they are there could clearly
14 be different because I think what would be
15 nice to avoid is -- and correct me if I am
16 wrong. But it has felt like sometimes there
17 is a discussion that has gone on about those
18 that like all-or-nothings and those that
19 don't. And so that becomes the discussion, as
20 opposed to if an all-or-nothing measure came
21 through and its four components are all
22 endorsed measures, what seems to be in front

1 of the committee is really just a question of
2 do we think those four things hang together?
3 Do they make sense? There shouldn't be a lot
4 of additional review about it, whether an all-
5 or-nothing is the right to do, especially if
6 NQF is saying as a principle, we endorse that
7 under certain circumstances.
8 There are other situations where
9 if somebody is bringing a composite that
10 weights those in different ways, then I think
11 there is an extra step, which is does the
12 weighting make sense. I mean then I would
13 think that you move into a different direction
14 with the committee of saying you also need to
15 assess whether the weighting is okay.
16 Now that may also not be a fair
17 distinction because why shouldn't the
18 committee say we want to assess whether all-
19 or-nothing is a kind of weighting. And so we
20 should have the same rights to do that.
21 So maybe there is no distinction
22 there at all.

1 DR. BIRKMEYER: But I actually get
2 that distinction. Kind of the all-or-none
3 measures for which at the end of the day there
4 is no empirical criterion standard at which
5 you are assessing this composite against.
6 There is no science underlying the weighting,
7 other than the collective judgment of somebody
8 that put these things together.
9 In that particular instance, sort
10 of the validity of the components is really
11 the only thing that you could assess. There
12 is the complete opposite end of the spectrum
13 with composites that they are being evaluated
14 against some criterion standard like mortality
15 with a procedure and all of the science is not
16 around the components and whether they are
17 valid but the statistical or other weighting
18 approach by which they get put together and
19 those to me feel like they need to be
20 evaluated with a different lens. And I don't
21 care like where they go or what they are
22 called, but they are very different.

1 DR. ZASLAVSKY: I will just repeat
2 the point I made to Patrick on the break is
3 that the kinds of issues that come up when you
4 put together, call them measures or items --
5 I guess we are not calling them measures if
6 they are not reported out. Whatever we are
7 putting together, the kinds of issues that
8 come up are some of the same issues come up
9 regardless of whether you are putting together
10 a bunch of things that are never events in
11 surgery or something like that or putting
12 together items on the CAHPS scale. And there
13 are different ways of doing that. And what I
14 am concerned about is that there should be
15 people in the room when those measures, those
16 consolidated measures, whether you call them
17 composites or not, are being evaluated who
18 understand some of the issues in deciding to
19 do all-or-none scoring versus a weighted
20 scoring versus an equally weighted scoring,
21 you know, different options that you might do
22 and that that kind of thinking is part of the

1 evaluation.

2 Whether administratively you want
3 to track things as being composites or not
4 composites, you know, that is more of an
5 internal NQF matter which I don't have an
6 opinion but it is the kind of thinking that is
7 brought to bear on analyzing these things.
8 Because I don't want a whole bunch of things
9 to be done as all-or-none things because
10 surgeons think of it that way or because
11 endocrinologists or cardiologists or whoever
12 is involved thinks about it that way without
13 having also some of the statistical
14 measurement expertise brought to bear in
15 examining that. And I am looking at whether
16 that makes that sense as the best of reporting
17 out that information.

18 DR. DE LONG: So I am under the
19 impression that not only is there a different
20 process but developers have to declare whether
21 it is a composite. And they have to follow
22 certain guidelines that are specific to

1 composites. I sort of side with Patrick that
2 maybe trying to make a distinction and forcing
3 them to recognize some of these things that we
4 don't seem to be in tune on could create more
5 confusion than is necessary. But I am not
6 sure what hoops they are jumping through that
7 they wouldn't ordinarily have to jump through
8 if it weren't a composite.
9 DR. BURSTIN: I think it is really
10 just what we are going to -- and you have it
11 in your packet, the distinction of what are
12 the additional requirements around evaluation
13 and submission that is different? And much of
14 this comes to the construct, how it comes
15 together, the testing around it. And at least
16 I think an important distinction from where I
17 sit is we are spending so much of our energy
18 these days focusing on related and competing
19 measures is how do we handle the component
20 measures within them? And do they need to get
21 fully evaluated on their own in a way that
22 allows us to do the related and competing and

1 make assessments of whether or not they are in
2 fact best in class. It becomes very complex
3 out there, whether there are measures that are
4 living in composites that don't necessarily
5 relate to the measures you are being paid on
6 for other kinds of purposes. So how do we
7 make sense of that?
8 So for me, I am being less
9 theoretical and more just practical of what do
10 we ask developers to submit? What do we ask
11 committees to consider? And those criteria
12 will be important.
13 DR. ROMANO: So initially NQF created a
14 composite measure evaluation committee that
15 produced this report that we all have. But
16 going forward, perhaps you could elaborate a
17 little bit, my understanding is that NQF is
18 expecting the individual topic-specific
19 steering committees to review composites
20 within their clinical or subject area domains.
21 Do we have people on each of those
22 committees that have the kind of expertise

1 that Alan is describing? We won't call it
2 psychometric expertise. We will call it
3 measurement science expertise. Do we have
4 people on all the committees that understand
5 these concepts about that the pros and cons,
6 the strengths and weaknesses of different ways
7 of combining multiple items or measures
8 together?
9 DR. BURSTIN: Right. We strive to
10 at least put a couple of methodologists on
11 every committee but it is a couple. It is not
12 like this room, certainly, where the
13 methodologists outweigh poor country
14 internists, as I will put myself in. But you
15 know at the end of the day we do have people
16 sitting there.
17 But one of the approaches we have
18 taken which we did as part of our large
19 outcomes project a couple of years back, is
20 every outcome measure got reviewed by a
21 statistician. Actually, Sean, which was
22 brilliant, worked really well. And one

1 question might be as a recommendation to this
2 committee is that we say outcomes and
3 composites should have a statistical review.
4 Almost like the annals always sends papers to
5 statisticians for a secondary review for
6 complex models. Is this complex enough that
7 you think that the average committee member
8 couldn't necessarily handle it?
9 I will tell you we have seen the
10 committees not necessarily get as worried
11 about the constructs as much as the fact that
12 this measure has all the components I think
13 are really clinically important. It is often
14 more clinically driven I think than it is
15 methodologically driven.
16 DR. ROMANO: Yes, and at the end
17 of the day this whole discussion is about how
18 to make NQF's processes work better to
19 provider clearer guidance for developers and
20 for steering committees.
21 DR. KAPLAN: I think that the
22 world has changed, as they said in one of

1 those trilogy of "The Lord of the Rings,"
2 because I think CMS amped up the stakes up
3 when now they are going to start -- you know,
4 when these are starting to be used for
5 compensation and I think one of the committee
6 meetings next week is going to look at some of
7 those very issues.
8 But I think the stakes are
9 different now and I think NQF is right to
10 worry about when you create these measures and
11 they get put out there and they get used for
12 paying people, you just ratcheted the fire up
13 substantially. So I think the shakedown might
14 even -- I don't know, Helen, what you think
15 but I think the shakedown now might have to
16 look different as things go forward.
17 DR. BURSTIN: Part of it Karen
18 just reminded me as well, as part of our
19 submission form, we already have a whole
20 section on risk adjustment if it is an
21 outcome. And maybe we don't have a separate
22 composite form per se but that every single

1 submission form, if it is a composite, answer
2 the following set of questions but not
3 necessarily create a whole separate event, but
4 maybe have those risk adjustment and those
5 composite approaches considered by experts as
6 well.
7 DR. ROMANO: So I think that is
8 sort of where we are sort of going that
9 instead of having a completely separate
10 process, that this would be viewed, the
11 composites would be viewed within the
12 ordinary, if you will, measure endorsement
13 process but that there might be some specific
14 declarations that measure developers are asked
15 to make to articulate what the higher order
16 composite, what the construct is, if you will,
17 and then what -- how they formed the composite
18 based on that construct. Does that summarize
19 people's views? Is that --
20 DR. DE LONG: We're still talking
21 about development because I think it does go
22 further in terms of evaluation and experience

1 with the measure as time goes on.
2 DR. ROMANO: So from that
3 framework then if I am getting this correct,
4 then we are not going to worry so much about
5 all of these different conceptual models,
6 three, four, five, six, seven and eight
7 because basically developers would simply be
8 asked to explain what their model was, what
9 their measurement construct was.
10 DR. BURSTIN: And then if you look
11 through it, I mean the only reason to actually
12 I think go through these a bit is there are
13 some special considerations, for example,
14 around the submission. So for example, what
15 you require is listed under one of these
16 specific testing at the performance score
17 level for composite measures. So we currently
18 allow testing at either the data element level
19 or the performance score level. If it is a
20 composite, does it have to also always be a
21 performance score level? We will come to that
22 when we start going through the criteria this

1 afternoon.

2 DR. SHAHIAN: So will -- if we

3 were to combine this in one measure form,

4 submission form an d no longer had a separate

5 composite, would we be in any way diluting the

6 additional requirements that we imposed in our

7 previous document for a composite measure or

8 simply be putting them into a different

9 pathway once you declare your composite?

10 DR. BURSTIN: I think it is the

11 latter, yes. So we would just not have a

12 whole separate forum. We would just try to

13 build in whatever those components are, if

14 this is a composite answer the phone and

15 questions as well.

16 DR. ROMANO: That leads into, I

17 think the third bullet point here, which is

18 there is this guidance that NQF has had before

19 that the components of composite measures have

20 to be separately endorsed or have to meet the

21 criteria for endorsement.

22 So does that even make sense? I

1 mean if we are taking this broader view of
2 composites, then it may be that for certain
3 types of composites there is no need to even
4 consider the performance properties of the
5 individual components. For others it may be
6 more important. I don't know. Do people have
7 thoughts?
8 DR. ZASLAVSKY: I think I want to
9 return to a comment I made earlier that it is
10 sort of a question of bias versus variance.
11 At least that is the simplest way to look at
12 it and if something would fail as an
13 individual measure because it is
14 insufficiently reliable, like something that
15 happens in one out of every hundred cases,
16 that doesn't exclude it from a composite
17 because you are putting it together with 20
18 other things that happen in one out of a
19 hundred cases and you are up to 20 percent and
20 there is a fair amount of information there.
21 So that is the kind of criterion
22 that you would not have to apply to the

1 individual components. But if something is
2 not acceptable as a performance measure
3 because it discriminates against hospitals
4 that treat sicker patients or because it is
5 something that should be adjusted for age and
6 it isn't or something of that sort, then that
7 criterion should be applied to the individual
8 measures.
9 You might, in some cases say that
10 I am putting together A and B and A catches
11 this group and B catches that group and when
12 you put them together you get something that
13 is fair, that would be legitimate. And so
14 that would be a case where you have kind of
15 offsetting biases of the different components.
16 But in general if something really
17 is either scientifically not valid or the data
18 usually can't be collected, if you have any of
19 those kinds of criteria or it is biased in the
20 senses I have been talking about, then I think
21 those criteria would apply even if it is being
22 put into a composite.

1 DR. DE LONG: So for example with
2 the HDL -- was it HDL or LDL -- you had an
3 either/or. And I think what you are saying is
4 that those two measures would not necessarily
5 be endorsed as stand-alone measures because
6 they don't really tell the story. You
7 wouldn't want to grade somebody on having the
8 LDL lower than something if the patient was on
9 a statin. But some measures really do need
10 introspection.
11 DR. ZASLAVSKY: Yes, that would be
12 a case where either measured by itself
13 wouldn't work and you have heterogeneous
14 patient populations with regard to their risk
15 for hyperlipidemia but put together you have
16 a fair measure of what cuts to this
17 appropriate practice.
18 MS. PAGET: How does this impact
19 the unpacking ability requirement that
20 currently sits in the criteria?
21 DR. ROMANO: What do you mean by
22 unpacking?

1 DR. BURSTIN: I used that term.
2 MS. PAGET: My understanding is it
3 is actually called decomposition, I mean
4 deconstruction, something but decomposing is
5 just like -- so when she said unpacking this
6 morning I said oh, I like that a lot better.
7 But my understanding is that we
8 want to be able to do kind of like of a
9 "Consumer Reports" type thing where you get
10 the red circle but then you can also look
11 across the chart because I often find that
12 there is not a lot of difference sometimes.
13 And even though you have got a bright red
14 circle, it is only a difference between a 94
15 and a 96 or something to that effect.
16 So I think the unpackability is
17 important and I just didn't know how this
18 relates to this issue of the individual
19 components being NQF-endorsed.
20 DR. DE LONG: It seems that the
21 developer should need to specify how this
22 measure if it contains more than one indicator

1 should be unpacked. Because in the example we
2 were just talking about, I don't think you
3 would unpack, would you?
4 DR. KAPLAN: To me compositing is
5 a lot like composting. So if you put together
6 a bunch of stuff in the compost heap and you
7 end up with fertilizer. But if you take any
8 of the eggshells and other stuff in there out,
9 they are still eggshells. But once they
10 interact with all the other stuff, now it is
11 fertilizer.
12 So decomposing, if you will, these
13 measures in some cases may not make any sense.
14 But making universal out of it isn't going to
15 work for you either. Because if you are
16 trying to -- some of these things may very
17 well stand alone and you are creating this
18 higher order or whatever we are calling it,
19 composite, to represent something else.
20 So that is where you get into the
21 now you are going to have to put people
22 through a different level of -- it is the same

1 measurement principles but they have to
2 demonstrate that they are actually now
3 measuring that something else, whatever it is,
4 fertilizer.
5 MS. PAGET: I guess I would just
6 say I would still want to know the pieces and
7 maybe in this case, it is not meaningful as an
8 individual but knowing what went into the
9 fertilizer, helpful.
10 DR. CHASE: I was trying to
11 understand that practically, too, I think we
12 want to avoid -- we want to have some guidance
13 here so we are not making measure submitters
14 or committees rehash stuff that has already
15 been decided. So again, when a component has
16 already been endorsed, that should give you --
17 I don't want say it gives you a pass but it
18 certainly should be a different level of
19 scrutiny. Because that I have experienced in
20 the committee work is you get a different
21 committee together, they may make a different
22 decision with the same evidence. So you don't

1 like to see that happening but that is what
2 you will start to build if you make people
3 rehash the same question over and over again.
4 So I think that is good but I think there
5 should be a different standard then or
6 guidance is when there is pieces that aren't
7 endorsed and they are there for a reason, you
8 have got to justify that and talk about what
9 is the -- there is a different level obviously
10 of review for those pieces, without making
11 them be submitted on separate forms. I was a
12 little worried when you mentioned
13 deconstructing shouldn't mean you have to
14 submit each piece to different committees,
15 unless it is totally different.
16 DR. BURSTIN: So just to follow up
17 on that, again if you think about what is in
18 our criteria and much of what Alan was talking
19 about was really about the scientific
20 acceptability of the properties. A lot of
21 what we are often talking about is the
22 evidence, though, for the individual

1 components. And so the question is, you have
2 got to be able to look up, if we are saying
3 those are not currently NQF-endorsed measures,
4 they have not been reviewed, the committee
5 needs to have enough information to really
6 understand whether the evidence for the
7 components is there. I mean, I am agnostic as
8 to whether it is a separate form or some other
9 little box that pops up or something but you
10 have got to be able to provide enough --
11 assuming we want to continue on the idea that
12 assuming we think the individual components
13 are really important, they are not endorsed,
14 they may add huge value to people out there to
15 actually have those individual measures out
16 there, what do we need to do to get the
17 committees enough information to make that
18 assessment? That is sort of where I am stuck
19 a bit.
20 DR. ROMANO: Well does it -- if
21 the measure developer is supporting the
22 unpacking concept, the drill-down concept, if

1 you will, then I think the implication of that
2 is that the unpacked measures have to be able
3 to stand on their own.
4 But if the measure developer is
5 not supporting an unpacking concept. In other
6 words, if the measure developer is saying that
7 you can't unpack this, that this is what is
8 necessary to measure the construct, my
9 construct, it might not be your construct or
10 somebody else's construct, in order to measure
11 my construct you have to include all of these
12 items. Maybe some of them have been
13 previously endorsed, some have not.
14 What is wrong with that?
15 DR. BURSTIN: I don't think there
16 is anything wrong with it. I guess I was just
17 questioning at times is the measure developer
18 always as a single entity, not a multiple
19 stakeholder environment, always the right
20 group to make the decision of whether it
21 should or should not be unpacked. If that is
22 value to a consumer -- let's think about Lynne

1 for example.

2 If she wants to be able to go
3 across the "Consumer Reports" page and in fact
4 see which of the component measures are really
5 driving that overall score, maybe one of them
6 is really important to her not having a
7 stroke.

8 I'm just making this up, David, a
9 bit. But you know, if stroke prevention --
10 not having a stroke plus CABG is really
11 important to her and she makes that decision,
12 should it always be in the decision of the
13 developer to say what should be unpacked and
14 what shouldn't? Just playing devil's
15 advocate.

16 DR. SHAHIAN: One of my concerns
17 is as we give more and more flexibility to
18 developers in how they navigate through the
19 system and which path to take, I think there
20 will always be a tendency to take the path of
21 least resistance and to choose the path which
22 requires the least oversight, the least

1 empirical justification and so forth.
2 So I am a little concerned that in
3 an era when we should, I think, be becoming
4 even more fastidious about how we approach
5 these measures, we may in fact be taking
6 things in an opposite direction and I would
7 hate to see that happen.
8 DR. CHASE: To make sure I
9 understand this, I think it would be helpful
10 to have guidance, too, around the opportunity.
11 You presented one earlier where I think it was
12 the GI where there were components that the
13 committee liked and some they didn't. It
14 seems a shame that the only alternative now is
15 to just say no. And if we say each submitter
16 should have the right to decide whether it is
17 packed or unpacked, people are always going to
18 say I think it all has to go together. But
19 the committee should have the ability to say,
20 we will endorse the four out of the five here,
21 we just can't go to five, and not force it to
22 have to go to a resubmission which, and

1 process-wise may mean you can't get it back in
2 a door for a while because we are wasting an
3 opportunity to get something valuable out
4 there sooner.
5 So I think it would be nice to
6 allow the composite committees to offer an
7 endorsement of less than the whole if it makes
8 sense to them. And the measure steward is
9 going to get to decide whether they want to
10 continue with it based on it. They could say
11 nice for you guys but then you go collect the
12 data, we are not going to do that.
13 DR. BURSTIN: The challenge there
14 then is that the measure testing that has been
15 put forward is based on what was submitted.
16 And this was an issue that has just recently
17 come up. If they would then say okay we hear
18 you, let's take out two of those components,
19 is their testing still valid? Is that okay?
20 DR. KAPLAN: Yes -- no. No. I
21 mean if for example you have got a seven-item
22 measure and now you are going to remove two of

1 those measures, you are going to take a
2 reliability hit just because of the way we
3 compute these composite or depending on the
4 way you compute these composite measures, the
5 odds are good that you are going to take a
6 reliability hit. The more things I measure
7 about a construct, the better I am about being
8 able to repeat it. So the consistency is
9 about repeatability, reproducibility. So more
10 things are better.
11 If you take two things out, now am
12 I good enough to compare one hospital to
13 another? What is my measurement area going to
14 be?
15 So without that kind of support,
16 but I think you should be restricting people
17 from adding things that they think improve the
18 precision of an estimate is not a good idea.
19 If we think that it is important
20 to estimate a complex construct with more
21 things, then what evidence does the measure
22 steward provide that that does actually

1 contribute to the reliability of the estimate.
2 If on the other hand you are going
3 to just toss the whole thing out and not allow
4 them some rejoinder to say well, we are not
5 sure but here is the evidence and here is the
6 face validity for these new things and here is
7 our guess at what it is going to do, and let
8 them model it, how much it is going to improve
9 the precision of this estimate. Why make it
10 go back to ground zero and just toss the whole
11 thing out?
12 DR. BURSTIN: I'm not saying it
13 has to. I am just saying those are the
14 realities of what we try to do in the course
15 of a project. I'm just being very honest
16 here.
17 But maybe that does speak to the
18 question if you are allowing the developer to
19 make the decision of pack/unpacked, then maybe
20 you have to have some pretty clear
21 requirements on the statistical evidence you
22 put forward for your packing. And I think

1 that is where we have actually seen a fair
2 amount of lacking in terms of saying if you
3 actually pulled out these, what would you --
4 and frankly, we see very little of that when
5 it is submitted to us, with a few exceptions.
6 DR. DE LONG: And I think that
7 speaks to current tension between the
8 proliferation of measures and having to record
9 all of these data when some of them aren't
10 really necessary to add into the mix.
11 So that proof that you mentioned,
12 I think is very important that each component
13 needs to provide some more information.
14 DR. BURSTIN: And not to forget
15 about one of our other requirements is
16 feasibility. There is a huge measurement
17 burden associated sometimes with the
18 collection of these data. And if you are
19 adding components and they are not having a
20 measurable impact on the outcome and it is a
21 lot of work to collect them, they probably
22 shouldn't be added. And then people also make

1 the case it is not always just data collection
2 burden, it is actually opportunity costs of
3 having to look at those 19 components to make
4 sure you are doing okay on the composite.
5 DR. CHASE: The burden goes the
6 other way, too, to the measure submitter that
7 we don't want to make it such a barrier. Say
8 you have got 19 components, you have got to
9 tell us the validity of each one, when you
10 only may have been able to test the 19
11 together.
12 And so that, I think there may be
13 some of these where it can go one way or the
14 other as far as that you could choose. In
15 other words if the committee felt like all 19
16 aren't valid, then you might have to provide
17 some data but you wouldn't always be required
18 to do all 19 because the committee may accept
19 it makes sense to have all the pieces
20 together.
21 DR. ROMANO: Yes, so let's say one
22 were to propose a composite that included a

1 bunch of process measures, for example. And
2 let's say that each of those process measures
3 or let's say that maybe some of them have been
4 NQF-endorsed, some of them haven't but they
5 are all just different processes of care. If
6 the developer can empirically demonstrate that
7 this composite is predictive of patient
8 outcomes and that it identifies providers,
9 hospitals, if you will, where patients will
10 have better outcomes, then do they need to
11 justify that there isn't bias in the
12 measurement of each of those components? Or
13 is it sufficient to say that the composite in
14 itself has desirable reliability and validity
15 properties and that supersedes, essentially,
16 issues about the validity of individual
17 components.
18 DR. BURSTIN: It is a great
19 question, Patrick. I will give a -- and not
20 to keep diabetes is such an obvious one, so I
21 am going to keep beating on it for a second
22 longer.

1 So let's say for example you have
2 got great evidence you have submitted that the
3 composite, the diabetes composite you have
4 submitted is highly predictive of outcomes,
5 clearly identifies patients where they would
6 have better outcomes, but there is individual
7 measures that directly compete with the
8 measures inside the composite, such that
9 clinicians are getting the individual measures
10 also put forward to them and they are getting
11 differing levels of performance requirements
12 across those. Should there at least be a
13 requirement that they are harmonized so that
14 you don't wind up with a clinician, doc,
15 whoever over here, saying I have got to do
16 140/80 over here but over here they have
17 140/90, they say A1c 8 base -- diabetes is of
18 course the worst example because it creates
19 more fights than any condition I have ever
20 seen in my entire life with the possible
21 exception of readmissions.
22 And so that is the issue for us.

1 Should we at least insist that there be --
2 even if you don't dive deep on the individual
3 reliability and validity of the components, do
4 you at least need to harmonize to the science,
5 I guess?
6 DR. DE LONG: Is there any reason
7 not to? Are there examples?
8 DR. BURSTIN: Yes, because people
9 have measures in use they have used for years.
10 It is not easy for people to flip on a dime
11 and change their measures. In this particular
12 example, to the current measurement they did.
13 They changed the blood pressure control level
14 so it matched the national measure of blood
15 pressure control. Is that something we should
16 push on for everyone? Is that important
17 enough to say that at least as they review the
18 evidence and we look at competing measures,
19 that even if we say it is fine, this measure,
20 the thing Patrick just rattled off that I
21 thought was great, it is clearly predictive of
22 outcomes. It clearly identifies patients

1 where they should go. It is valid. There is
2 no bias. Do we still need to at least unpack
3 to the extent of saying the evidence is sound
4 and if there are related or competing
5 measures, they are harmonized?
6 DR. DE LONG: Well you are asking
7 two questions.
8 DR. BURSTIN: I know.
9 DR. DE LONG: In the
10 harmonization, the reason not to is it is
11 inconvenient because of historical precedent.
12 But it is also inconvenient for people who are
13 trying to deal with these and which one weighs
14 more.
15 DR. BRATZLER: This is Dale. I
16 think Helen, wherever possible it makes sense
17 to try to harmonize the metrics, particularly
18 where there is a strong evidence base to
19 support perhaps the individual measure that
20 you are comparing to. I just think it is
21 really hard for clinicians to deal with
22 competing measures.

1 MS. PAGET: Just one other comment
2 on the unpacking and the science and the
3 underlying pieces of the unpacking.
4 You know I think if we look ahead
5 at where we are going from a technology
6 standpoint and usability and accessibility of
7 information for both patients, providers,
8 institutions, and payers, we are going to have
9 -- it is going to be easier and not harder.
10 And so I think to move in a direction where we
11 weren't offering the kind of transparency that
12 people are experiencing in other aspects of
13 their lives would probably be somewhat of a
14 mistake. I think the transparency also about
15 the purpose of the measurement and the pieces
16 that went into the packing has to be really
17 clear, particularly to consumers, so that we
18 don't run into that problem with people
19 wanting to identify one thing that may not
20 have the scientific rigor that we wanted to.
21 But I do kind of come back to that
22 Consumer Reports model and I think your point,

1 Helen, is right on. I mean I often find
2 myself saying well that piece is, I'm okay
3 that they didn't score that high there but I
4 am really happy that they got this other
5 score. I mean I have got a kid I hope is
6 going to go to college next year. And you
7 know you go through all these numbers but it
8 is when you piece them apart that the tool
9 that you use becomes much more advantageous,
10 I think, in that kind of decision-making.
11 So I just think if we keep in mind
12 where we are headed around how we are using
13 our phones and everything else that that piece
14 is going to become more important.
15 DR. ROMANO: If I am sensing where
16 we are, so I think that what we are saying is
17 that certainly NQF should continue to endorse
18 measures that contain measures that aren't
19 separately endorsed. And if they are
20 separately endorsed, that may streamline the
21 process a bit because you may be able to rely
22 on the validity evidence in particular that

1 was presented through that separate
2 endorsement process to say that these
3 components are assumed to be valid as
4 components, not for the higher order construct
5 but as components. They are assumed to be
6 valid.
7 But if there are other measures
8 that are rolled up into a composite that are
9 not NQF-endorsed, then what do measure
10 developers need to do? So do measure
11 developers need to present evidence that those
12 other unendorsed components are in and of
13 themselves valid or do they simply have to
14 present evidence that those other unendorsed
15 components contribute favorably to the overall
16 composite?
17 DR. SHAHIAN: Going back to my
18 work with the evidence task force, perhaps we
19 could say that for component measures that
20 were not NQF-endorsed that at least the
21 developer would present the kind of evidence
22 that normally would lead to endorsement such

1 as the quality, quantity, and consistency, and
2 magnitude of net benefit of the proposed
3 measure.
4 So parallel the kind of grading
5 system that NQF uses, which is based on grade
6 and USPS -- United States Public -- I always
7 get that acronym -- you know what I mean.
8 (Laughter.)
9 DR. BURSTIN: USPSTF.
10 DR. SHAHIAN: But at least have
11 some sort of explicitly defined criteria by
12 which those non-NQF-endorsed components could
13 be evaluated.
14 DR. BIRKMEYER: I agree with
15 everything that has been said but I think it
16 is also important to not lose sight of how
17 heterogeneous these measures are, in terms of
18 how they are put together and how they are
19 used. And I think ultimately we might want to
20 insist that we grade each of like several
21 measures that are put forward, have them get
22 graded in each of three or four different

1 domains. But at the end of the day, there
2 needs to be like some holistic judgment that
3 sort of rates those component grades against
4 how it is to be used and it would be very
5 analogous to how we rate grants that are
6 submitted to the NIH, get a letter grade for
7 the significance, a letter grade for the
8 innovation and environment and methods, et
9 cetera, et cetera. But at the end of the day
10 what determines whether it is in or out or
11 where it ranks is the impact, which is not
12 just an averaging of those letters. It is
13 basically weighting them according to a
14 variety of other factors.
15 So a composite approach to scoring
16 the composites.
17 DR. KAPLAN: Sometimes the
18 evidence also comes from different levels. And
19 now there is a new purpose. So now you have
20 got these diabetes measures that we know some
21 of the hemoglobin A1c, for example, predicts
22 photocoagulation somewhere down the way. So

1 we know at the patient level that that is what
2 these individual components do.
3 What we don't know is when you add
4 them all up are you evaluating physician
5 components? What components of the variation
6 belong to the patient? There is nothing the
7 doctor can do about that. What components of
8 the variation belong to the doctor?
9 So are you asking, and I am just
10 throwing this out, when you are using it for
11 a different reason than the evidence
12 substantiates its intent for, are you now
13 going to challenge the stewards to provide
14 evidence that actually it is okay? What is
15 the reliability and validity for use at a
16 different level than the evidence supports?
17 DR. ZASLAVSKY: Just to elaborate
18 on what I think both John and Sherrie were
19 saying. I think that often as a practical
20 matter, measures are developed based on a
21 limited amount of data in some pilot study
22 that someone has done. So you go out and you

1 test something in seven hospitals or with 30
2 physicians or whatever. And you come up with
3 a model that looks like it is pretty good, it
4 seems scientifically plausible and so forth.
5 But now what you would really like
6 to know is whether you can use this to make
7 comparisons among hospitals. And you can't
8 say anything based on the ten hospitals you
9 are able to recruit to your pilot study about
10 whether it really predicts outcomes at that
11 level.
12 So in that case, I think you need
13 to give a kind of a qualified or kind of
14 provisional approval that says on the evidence
15 we have, there is enough here that makes it
16 worthwhile to do what is a substantial
17 investment people are going to have to do
18 before it is fully validated at the level that
19 you want to validate it at.
20 And then take note of the fact
21 that it is really a requirement that the data
22 that further implementation that takes place

1 be brought back for either confirmation or
2 improvements or maybe invalidation, you hope
3 not, of what you did provisionally based on a
4 more limited evidence base because you are not
5 going to get those big evidence bases that you
6 really need to be really confident that this
7 is doing the right thing until you have
8 actually given some level of endorsement to
9 it.
10 DR. SHAHIAN: I guess I would just
11 respond to that by saying that in 2012 and
12 going forward, the stakes are so high that I
13 would say it ought to be incumbent on the
14 developer to do whatever needs to be done to
15 prove that before they come to NQF. I mean,
16 we just can't have more and more measures for
17 which we don't have sufficient evidence.
18 DR. BURSTIN: So this is actually
19 very helpful. It sounds to me that we are
20 saying still yes, we should at least assess
21 the evidence of the component measures. It is
22 important to note that the Evidence Task Force

1 in our final guidance, at least, indicated
2 that for outcome measures, there was only a
3 requirement for a rationale. So it doesn't
4 have quite as much and a lot of these wind up
5 being outcomes. So I think that is just, I
6 want to at least put that on the table.
7 The final bullet up here though is
8 what I am hearing and tell me if I am hearing
9 this correctly is that what is sort of at the
10 highest level is the reliability and validity
11 and the performance of the final composite
12 performance measure but that whether or not we
13 require additional analyses of the components
14 is something that might be a decision that the
15 developer may put forward to say this measure
16 actually really only operates at the level of
17 a composite performance measure. We don't
18 necessarily think the individual ones do but
19 they are important for the sake of the
20 composite.
21 So I am getting the sense we are
22 leaning towards saying no for the final bullet

1 there, additional analyses for the components,
2 unless the developer believes those are stand-
3 alone measures that should be evaluated for
4 endorsement.
5 Am I am capturing this discussion?
6 DR. DE LONG: I thought there was
7 another issue which is are they necessary.
8 DR. BURSTIN: Right but necessary
9 still to me seems like necessary to the final
10 composite performance measure --
11 DR. DE LONG: Yes.
12 DR. BURSTIN: -- as opposed to
13 individually.
14 DR. DE LONG: Right.
15 DR. BURSTIN: And we haven't done
16 anything new on that.
17 DR. DE LONG: Okay.
18 DR. ROMANO: Just to make sure I
19 understand this concept of necessary.
20 So are you talking about necessary
21 conceptually or necessary empirically? There
22 may be a distinction where you may have

1 things, for example, that don't contribute
2 anything empirically because they are highly
3 correlated with other things or because they
4 are almost always done.
5 But people might argue from the
6 face validity perspective that it is a
7 fundamental component of what should be done.
8 It is or from the outcomes perspective, that
9 it is an important outcome. So even if it
10 doesn't -- I'm just posing sort of a devil's
11 advocate question.
12 DR. DE LONG: No, I think that is
13 a good question. I am coming from the
14 empirical evidence and the point of view that
15 I believe we have kind of overshot the target
16 in terms of how many performance measures we
17 are getting people to record and report and
18 look at. And to the extent that we can be
19 more parsimonious I think that will be very
20 helpful.
21 So if there are, for example,
22 aspirin on discharge for an AMI, apparently

1 that contributes nothing. Is it important
2 because it makes sense to include it in a
3 composite when it doesn't add? I would say no
4 but others may yes.
5 DR. ROMANO: The question is does
6 the developer have to show that it adds
7 empirically or is it sufficient to show that
8 it adds conceptually, in other words that
9 clinicians, patients feel that this is
10 important or do you also have to show that it
11 adds empirically? That is the standard for
12 review.
13 DR. KAPLAN: I was at a meeting of
14 a bunch of physicians, a very large group of
15 physicians and I was basically the lone
16 psychometrician in the group but I was
17 presenting the physician-level performance
18 measures for diabetes. And it turns out that
19 blood pressure outcome does not hang together
20 with the other outcome measures empirically.
21 So I said well we got rid of it.
22 It actually improved the precision estimate.

1 We did a chrome block alpha. It improved the
2 precision estimate at the physician level. I
3 must have had 20 hands up exploding at me
4 saying my patients are more likely to die of
5 a stroke than anything if their hemoglobin A1c
6 is in control for their whole life. So what
7 are you doing throwing out blood pressure as
8 a measure?
9 Well it was justifiable and
10 actually very justifiable at the empirical
11 level but there are times when it is just so
12 entrenched in the credibility of a measure.
13 If you leave it out, you do it at your peril.
14 So just so you know, sometimes crass
15 empiricism can really taking you down a dark
16 hole and for NQF's sake, I would like at least
17 the inclusion of the potential for if not
18 empirically supported, at least the
19 substantive rationale and leave it the way it
20 is.
21 DR. ROMANO: Thank you for stating
22 my concern more clearly.

1 DR. SHAHIAN: But the other side
2 of that, of course, is when NQF endorses a
3 measure, it goes to CMS. CMS rolls it out.
4 It has a two or three percent impact on
5 hospital reimbursement for all Medicare
6 admissions. Hospitals push back and say I
7 would like to see the evidence for that
8 component of that measure. And you say well,
9 people thought that that was important. That
10 is the other side.
11 DR. ROMANO: Well perhaps some of
12 it gets back to what the construct is. In
13 other words, the clinicians who exploded at
14 Sherrie's meeting were right in that stroke is
15 an important outcome for diabetic patients and
16 hypertension is an important risk factor for
17 stroke and, therefore, controlling blood
18 pressure has to be recognized as an important
19 component of treatment for diabetic patients.
20 Even if it doesn't hang together empirically
21 and add to the composite, it clearly is
22 related to patient outcomes. So if we are

1 trying to pitch a composite as being useful
2 for decision making by patients, how can we
3 ignore hypertension?
4 DR. DE LONG: That brings up what
5 was this measure for?
6 DR. KAPLAN: It's actually -- we
7 published it and it was for assessment of
8 physician performance of diabetes care. And
9 so we took the NCQA diabetes recognition
10 program data and sampled patients at the
11 physician level and all that stuff and got
12 these performance estimates at the physician
13 level. That was supposed to be and it was
14 used in whatever the acronym is for the
15 recognition program in diabetes and NCQA. So
16 it was to be used at the physician level.
17 The question is not whether or not
18 high blood pressure at the patient level is a
19 bad thing to happen. The question is whether
20 used as a performance measure for estimating
21 physician performance, it contributes, and it
22 does not.

1 So if you look at the physician
2 effect on blood pressure, forgive me for the
3 clinicians, it is buckshot. There is no
4 signal for physician effect on the blood
5 pressure outcome measure.
6 There is a signal for glycated
7 hemoglobin. There is a signal for LDL. But
8 there is no signal for the blood pressure
9 outcome and that is why it wasn't able to
10 contribute to the variability and physician
11 performance measure.
12 So it kind of depends. I wouldn't
13 put anybody through that analysis. That is
14 way in the future. But for the sake of, and
15 because I got myself into terrible trouble by
16 excluding that, for credibility sake, and I
17 appreciate the issue of credibility versus
18 evidence, I think they are going to be a
19 tension going forward in how we put these
20 measures together until we are much more
21 sophisticated in our audience.
22 DR. DE LONG: Not to dwell on a

1 minor point but the physicians were up in arms
2 because you weren't measuring was it blood
3 pressure control?
4 DR. BURSTIN: Yes.
5 DR. DE LONG: Even though they
6 have no impact on it?
7 DR. BURSTIN: Well I think that is
8 debatable.
9 DR. KAPLAN: Apparently they think
10 they do and empirically it didn't show up.
11 DR. BURSTIN: Dual versus group.
12 DR. KAPLAN: Yes.
13 DR. BURSTIN: Of course. I do
14 impact blood pressure, I am convinced of it.
15 So I think that is a tough example.
16 I do have one question that raises
17 for me, though, which is that we do oftentimes
18 as we get into the criteria discussion this
19 afternoon, we have rating scales for some of
20 these things. So one question might be for
21 the composite do you get extra points if you
22 do both empiric and conceptual. And there may

1 be it is modern and acceptable if you do one
2 or the other but to David's point, if these
3 really are sort of some of the higher stakes
4 measures, people may not be happy having it
5 just be one or the other. Moderate may not be
6 good enough going forward. But that may just
7 be one way to do it. So quantity, quality,
8 consistency it is as clear as could be that is
9 high. You have to have consistency. That is
10 a no-brainer. You are low if you don't have
11 consistency. And maybe there is sort of a
12 similar construct we need to think through
13 about what is the requirements for the
14 composite.
15 DR. WRIGHT: But that implies
16 value. So you want to be clear about that
17 that you are evaluating one type over another.
18 And if that is what you want to do, fine.
19 DR. BURSTIN: Another thing
20 valuing one or the other, the question is is
21 there value of having both that is additive
22 beyond one or the other. I'm not saying -- I

1 wouldn't even know how to pick between the two
2 of them. But is there added value, if in fact
3 you have demonstrated both?
4 DR. WRIGHT: Yes, both would be
5 fine but I would want to differentiate between
6 the two.
7 DR. DE LONG: And once again, you
8 are measuring physician performance. There
9 are outcomes like stroke that are being sort
10 of also evaluated among these patients.
11 Wouldn't -- do we want blood pressure in both
12 of those measurements -- measures?
13 DR. KAPLAN: This is where you get
14 into the weeds. I think it is probably not
15 worthwhile pursuing all this stuff. But the
16 point was if there is a clinical rationale for
17 including something versus an empirical
18 rationale, maternal mortality is probably a
19 better example. It never happens but when it
20 does, it is really bad.
21 So even though probably
22 empirically it wouldn't make it into a measure

1 of hospital performance, clinically it is so
2 devastating, you had better put it in there as
3 a reflection of -- you know, that is just an
4 example. But I think sometimes we get into
5 the crass empiricism way too much.
6 DR. ROMANO: So lunch is here.
7 Should we -- okay.
8 DR. BURSTIN: Do you want to just
9 see if Dale wants to say something?
10 DR. ROMANO: Yes, so I think we
11 are reaching a breaking point in our
12 discussion.
13 (Laughter.)
14 DR. ROMANO: Dale, would you like
15 to add anything at this point?
16 DR. BRATZLER: No. It has been a
17 fascinating conversation.
18 DR. ROMANO: Okay, should we open
19 to public comment, then? Is there anyone else
20 on the line? Can we open the line?
21 DR. BURSTIN: And also in the
22 room.

1 DR. BURSTIN: Monica, can you open
2 the lines for us for public comment, please?
3 OPERATOR: At this time, I would
4 like to remind everyone in order to ask a
5 question, press *, then number 1 on your
6 telephone keypad. We will pause for just a
7 moment to compile the Q&A roster.
8 At this time, there are no
9 questions.
10 DR. BURSTIN: Thank you.
11 MS. CRAWFORD: Thank you. I just
12 wanted to speak really briefly.
13 Thank you. My name is Alyssa
14 Crawford. I am here from Mathematica Policy
15 Research and we have a number of measure
16 development projects with a number of other
17 partners and for a number of agencies.
18 I just wanted to speak up really
19 briefly because I think a lot of the
20 discussion in the past 30 minutes, in
21 particular, has applied to a lot of the things
22 we have discussed internally. And I wanted to

1 put out a plug that I think there is a
2 difference between a lack of evidence and
3 evidence of a lack of effect when it comes to
4 scientific acceptability. And to some extent
5 when it comes to evidence, sometimes there is
6 just a lack of evidence to support whether a
7 concept is actually improving outcomes and
8 that doesn't necessarily mean it doesn't
9 improve.
10 We have seen this in particular in
11 certain measure development areas such as
12 behavioral health, where there is just not as
13 much evidence out there to support. And there
14 aren't as many measure out there in the field
15 for people to choose from. So I just wanted
16 to bring that to the group for consideration.
17 DR. BURSTIN: I'm sorry. Lack of
18 evidence versus -- could you just do the
19 second --
20 MS. CRAWFORD: Sorry. I think
21 there is a difference between evidence of a
22 lack of effect and a lack of evidence of an

1 effect. So whether or not you have evidence
2 to prove that there isn't reliability and
3 validity, versus the evidence doesn't
4 necessarily support it.
5 DR. BURSTIN: Right. And NQF has
6 an evidence exception specifically for those
7 areas that we invoke as necessary. We try not
8 to use it very often but specifically to say
9 we recognize there are times when the evidence
10 is just not there yet. We don't invoke it
11 very often, for example, spiritual care and
12 palliative care. Again, weighting for those
13 studies seem unnecessary and we specifically
14 allow the committee to put forward their
15 expert judgment and invoke the exception to
16 say in this instance, the benefits
17 significantly outweigh the risks to patients.
18 But thank you.
19 DR. ROMANO: Okay, so not hearing
20 any other questions, we will break for lunch.
21 What time will we come back, for
22 Dale's benefit? One o'clock. So we will

1 reconvene at one o'clock.

2 DR. BRATZLER: Okay, I am going to

3 hang up and I will call back in.

4 (Whereupon, the above-entitled

5 matter went off the record at 12:20 p.m. and

6 resumed at 1:10 p.m.)

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

2 (1:10 p.m.)

3 DR. ROMANO: Okay, so we will
4 reconvene. Thank you again for joining us,
5 those of you who are on the phone. I think
6 our task for this afternoon really shifts into
7 the weeds, where we go from kind of a broader
8 conceptual discussion into looking at the
9 specific measure evaluation criteria. Do we
10 have a side on that by the way? We probably
11 shouldn't keep that slide up.

12 So I think all of you in your
13 packets have a number of relevant materials.
14 So you have the measure evaluation criteria
15 from January 2011 that are currently used by
16 NQF and you have a table that summarizes, it
17 is called Table 1. It summarizes individual
18 and composite measure evaluation criteria.
19 And this is a nice table because in the left
20 panel it highlights the criteria that are used
21 for evaluating individual measures and then on
22 the right panel, it shows how those criteria

1 are altered or added to if a measure developer
2 declares that they are submitting a composite
3 measure.
4 And then there is another sort of
5 12-page document here that represents what
6 measure developers actually have to fill out
7 currently for composite measures. We will not
8 go through the 12-page version of this
9 although some of us have done so but it is
10 here for your reference and the message is
11 that each time we say that there should be a
12 certain criterion or a sub-criterion, that NQF
13 staff has to convert that into a box, an item
14 on this form or a set of boxes or items that
15 measure developers then fill out.
16 So if you have thoughts about how
17 that should be done, please feel free. We
18 won't be going through the form in detail but
19 please feel free to offer your thoughts as we
20 go through the discussion.
21 Now I think Karen and Karen was it
22 also came up with this table that is part of

1 the first agenda packet, the briefing memo.
2 It is called DRAFT Table 4. So I would ask
3 that people sort of have in front of them --
4 okay, we have it on the screen as well. So
5 there is DRAFT Table 4. So this shows the
6 current additional criteria for composites and
7 considerations that have been raised by NQF
8 staff and through previous NQF steering
9 committee processes.
10 So what we will be doing is we
11 will be going through Table 1 that is in your
12 packet with the current individual and
13 composite measure evaluation criteria. We
14 will be going through the considerations that
15 are shown here for this DRAFT Table 4 and we
16 will be making recommendations to NQF about
17 specific wording changes, specific
18 operationalization.
19 So to start in Table 1, just to
20 give everybody a frame because some of you
21 have gone through the process as developers or
22 as Steering Committee members but others may

1 not have. So there are four conditions for
2 consideration that must be met before proposed
3 measures may be considered and evaluated for
4 suitability. This is true across the entire
5 enterprise.
6 The measure has to be in a public
7 domain or an intellectual property agreement
8 as signed. There has to be a responsible
9 entity and process to maintain and update the
10 measure. The measure has to be intended for
11 both public reporting and quality improvement
12 and those terms are defined broadly. So it
13 could be public reporting in any context,
14 quality improvement in any context. And then
15 D, the measure submission itself has to be
16 complete.
17 So those four considerations I
18 don't think would be altered here because they
19 apply across the enterprise. Right?
20 DR. BURSTIN: Right.
21 DR. ROMANO: Okay. So we will go
22 into the next -- everybody with me?

1 So we will go into now the first
2 of the four formal criteria for measure
3 evaluation, that is, importance to measure and
4 report. So importance to measure -- oh.
5 Okay so before we do that. So I
6 think that we have agreed this is on what is
7 labeled as page nine of this Table 1, criteria
8 for evaluation. So currently composites have
9 this higher level criteria for evaluation that
10 says that the individual measures included in
11 the composite must be either NQF-endorsed or
12 assessed to have met the individual measure
13 evaluation criteria as the first step in
14 evaluating composite measures. So I think we
15 have agreed that we are actually dropping the
16 second part of that or statement.
17 Can we put that up on the screen?
18 Do you have that? Okay, let's put it up on
19 the screen just so everybody is clear about
20 it.
21 Because this is kind of the first
22 step. So what Liz and I heard, I think, and

1 Karen and Helen from this morning's discussion
2 was that rather than requiring every component
3 of a composite to be either NQF-endorsed or to
4 have met the measure evaluation criteria for
5 endorsement, what we are asking for instead if
6 the components are not NQF-endorsed is that
7 there be some evidence for its inclusion in
8 the composite. If we could scroll down a
9 little bit. Okay.
10 So the second part of this or
11 statement would be that there should be some
12 evidence for the inclusion of components that
13 are not already NQF-endorsed. And that
14 evidence could be either based on the -- or
15 probably both. Maybe it is both. But it
16 should be based on the individual performance
17 characteristics of the component, particularly
18 validity as Alan pointed out earlier.
19 Reliability may be completely immaterial for
20 a component of a composite but there may be
21 evidence based on individual characteristics.
22 Next page. There we are. Thank you.

1 Okay, so rather than saying or
2 assessed to have met the individual measure
3 evaluation criteria I think what we are
4 looking at is or there is evidence for its
5 inclusion in the composite based on either the
6 individual -- its performance characteristics
7 and individual measure or based on its
8 contribution to the performance of the overall
9 composite.
10 That contribution could be
11 described, in most cases empirically but in
12 some cases it might be described conceptually
13 as we discussed with Sherrie's example of
14 blood pressure this morning.
15 Does that capture the sense of the
16 discussion in the latter part of the morning?
17 Okay, so we are fairly fundamentally changing
18 the second part of that or statement.
19 Okay. So given that, then let's
20 move on to criterion one, which is importance
21 to measure and report.
22 DR. SHAHIAN: So just before we go

1 on, just in terms of the optics of what we are
2 doing, we just went through a process two
3 some-odd years ago where we tightened the
4 evidence criteria and made them much more
5 explicit. Will this be viewed as a weakening
6 of the evidence criterion? I'm just asking.
7 DR. BURSTIN: It is actually
8 interesting because I thought we were going to
9 just go to the criteria first and then try to
10 figure out where we are on the bigger one
11 because it is a little fuzzy for me still.
12 Because I think what we said earlier was we
13 still wanted evidence until we get to the next
14 criteria. We are still expecting evidence
15 and, I would argue, performance gap as well
16 for the components.
17 So we may need to nuance this
18 wording a bit.
19 DR. BIRKMEYER: But I think that
20 while I agree that we shouldn't roll back the
21 tide with regards to evidence, I think that
22 the focus should be on sort of the evidence

1 around how well the summary score works in the
2 context of what we are talking about here,
3 rather than each component that rolls up into
4 it.
5 DR. ROMANO: So in a way we may be
6 lowering the bar for components but we may be
7 raising the bar for the composite as a whole
8 and for ensuring that the construction of the
9 composite is based on a clear construct, a
10 clear quality construct.
11 DR. BURSTIN: Does that work for
12 you?
13 DR. BIRKMEYER: I think so.
14 DR. BURSTIN: Okay. Since you
15 chaired the evidence Task Force.
16 DR. ROMANO: Okay, so let's look
17 at the importance issue. And so what was done
18 before, three years ago was it, was that
19 criteria 1a, b, and c were retained but new
20 criteria 1d and e were added for composites.
21 So 1a is about a high impact
22 aspect of healthcare; 1b is about a

1 demonstration of opportunities for
2 improvement; and 1c is about the evidence
3 base, if you will. Is that an appropriate
4 summary? Okay.
5 So the additional evaluation
6 criteria that were added for composites, 1d
7 was that the purpose/objective of the
8 composite measure and the construct are
9 clearly described and 1e is that the
10 components are consistent with and
11 representative of the construct.
12 So could everybody just read 1d
13 and 1e as we are talking and think about how
14 those should be changed or adapted, based on
15 our discussion?
16 Basically what NQF staff said here
17 is that this has been difficult to apply in
18 practice. These criteria 1d and particularly
19 1e. 1d would seem to be relevant to every
20 performance measure and not unique to
21 composites but I think we have already said
22 that there is a blurry line and probably most

1 of the measures that are endorsed by NQF are
2 composites if you really look at them closely.
3 And 1e seems difficult to apply in
4 practice. So any thoughts or responses to
5 those considerations?
6 DR. ZASLAVSKY: It seems that the
7 piece of 1d that might need to be made more
8 explicit is that the method of forming the
9 composite has to be justified by reference to
10 the objective of the composite measure and the
11 conceptual basis of the composite measure.
12 That is what we were talking about this
13 morning and it isn't really in that -- that is
14 what is different for a composite as opposed
15 to anything else.
16 DR. ROMANO: The method of forming
17 the composite from the components has to be
18 clearly linked to the purpose and objective of
19 the composite measure. Is that what you are
20 saying?
21 DR. KAPLAN: Yes, I was missing
22 the appropriate part. And they have to be --

1 the purpose has to be described and it has to
2 be appropriate.
3 DR. ZASLAVSKY: Not related by
4 virtue of being involved with this.
5 (Laughter.)
6 DR. ROMANO: Anything can be
7 described. So you can describe a method for
8 adding together apples and elephants.
9 DR. CHASE: So let me test this
10 forward because I can see where this gets
11 difficult. Again, if a purpose could be well
12 there is a whole bunch of criteria that we
13 have collected and they are individually
14 valuable, it makes them easier to understand
15 if we combine. Then just about everything
16 people are going to bring is going to meet
17 this. Or are we saying that is never a reason
18 to do composites and yet I think that is a
19 reason why people are doing composites
20 sometimes.
21 Again, take a prevention
22 composite, which would stand alone on each one

1 of its components and I might well want to
2 bring it just because why give people nine
3 things to look at when they could look at just
4 one.
5 DR. ROMANO: Well let me just push
6 back a little bit and say that making it
7 easier is not clear enough. That you have to
8 say making it easier to do what. Making it
9 easier for making what decision that is
10 relevant in this marketplace?
11 DR. KAPLAN: Yes, I mean the
12 purpose -- I would separate those two. The
13 purpose has to be explicitly articulated. The
14 rationale for creating a composite has to be
15 explicitly articulated and then the
16 appropriate of use for whatever construct for
17 the purpose of is appropriate.
18 So I would separate the two
19 things. One, you have to have -- the purpose
20 has to be explicitly articulated and then the
21 methods and the construct have to be
22 appropriate for that purpose.

1 DR. ROMANO: So then what I am
2 hearing is that 1d has essentially two
3 subcomponents, where the first subcomponent is
4 related to explicit articulation of the
5 purpose and the second subcomponent is related
6 to how the methods follow from that purpose,
7 the appropriateness of the methods based on
8 that purpose. Is that what people are saying?
9 I see some nodding.
10 DR. BURSTIN: It might be helpful
11 to actually just to use an example. Let's
12 keep on Jim's example for a moment.
13 So somebody takes all the
14 currently endorsed NQF-endorsed measures
15 around prevention and screening. Let's just
16 make it easier, just a screening composite and
17 brings it forward. What would need to be --
18 just give me a sense of what you think would
19 be an acceptable explicitly articulated
20 purpose for a screening composite.
21 DR. CHASE: My argument would be
22 again when I said ease, I meant for a consumer

1 to look at one indicator of the overall
2 prevention that a given provider organization
3 provides.
4 DR. BURSTIN: That works for me.
5 I'm just curious if it works for everybody
6 else.
7 DR. CHASE: And later in the
8 process might come the test of is that a valid
9 thing to do, to combine all seven for
10 performance.
11 DR. ROMANO: But I think what is
12 maybe needs to be a little bit clearer again
13 relative to what developers are used to doing
14 is that this is intended as a measure that
15 consumers could use to choose physician
16 organizations, provider organizations that
17 provide a higher quality care in prevention
18 and screening.
19 Is that -- yes. So that makes it
20 different, for example, from a measure that --
21 so you could formulate a different composite
22 where some of the words would change but it

1 would have a very different construction
2 because it would be designed for payment
3 determination, for example, for providing a
4 financial reward to provider organizations
5 that are improving patient outcomes.
6 DR. BURSTIN: -- for specific
7 purposes so that gets funky.
8 DR. ROMANO: All right, I
9 understand that.
10 DR. KAPLAN: Well like --
11 DR. ROMANO: You can't avoid the
12 problem.
13 DR. KAPLAN: American Board of
14 Internal Medicine did these performance
15 improvement modules and they created
16 prevention, chronic care and acute care as the
17 performance things they were trying to
18 evaluate. Well the prevention thing didn't
19 work so well. It doesn't hang together too
20 well. The acute care not so well but the
21 chronic disease care worked really well at the
22 physician level.

1 So the point of those measures was
2 to create a composite out of the things they
3 have already -- you know that are already
4 around that looked at the doctor's ability to
5 provide high quality chronic disease care for
6 their patients. So that was the underlying
7 purpose and then they combined all these
8 measures in ways that we helped them with to
9 provide the empirical, the evidentiary support
10 that actually those measures were appropriate
11 for evaluating physician performance in terms
12 of the chronic disease care provider.
13 So that is another -- it is a
14 different example but it is another kind of
15 way of looking at if you have got a new
16 purpose out there, you are going to combine
17 these things differently and then we are going
18 to ask you to state what that purpose is and
19 how you are going to do it.
20 DR. ROMANO: If they don't --
21 let's take that example. If they don't hang
22 together empirically, then what do you say?

1 Do you go back to Jim and say you cannot do
2 this because they don't hang together
3 empirically or do you say you can do this but
4 consumers ought to know that prevention for
5 men's health doesn't necessarily correlate
6 with prevention for women's health or
7 prevention related to breast cancer screening
8 doesn't necessarily correlate with prevention
9 in other domain. How do we respond?
10 DR. KAPLAN: Well I am not NQF.
11 So how I would respond is differently. I
12 would say those measures that you just handed
13 over don't look to be good measures of
14 physician performance. They may be very good
15 measures of planned performance or they may be
16 very good measures of patient something or
17 other but they don't look like they are very
18 good measures of physician performance unless
19 you have more of the same things. In other
20 words, as a measure of physician performance,
21 this may not shake up.
22 Now, should that paralyze us from

1 never doing physician performance levels of
2 prevention or are we at such a crude state of
3 understanding this process that we will take
4 whatever it is they offer us up because we are
5 not sure that they are not very good measures
6 of physician performance, for exactly the
7 reason I stated. There may not be enough of
8 them. They may have too much patient
9 variability. The doctors may be attracting
10 patients with certain kind of wellness
11 profiles and so on.
12 But I would at least like to hear
13 some language in there about here is what you
14 are trying to do. Here is what your intention
15 is, and here is the methods you are setting
16 about to accomplish that.
17 DR. BURSTIN: It feels like we are
18 blending two criteria. So for me at least
19 there is the evidence, which I think is
20 different. This one about impact evidence and
21 opportunity for improvement feels different to
22 me than the empiric basis that we are now

1 talking about.

2 So I guess one question is going

3 back to David's comment that if we are raising

4 the bar on the composite overall around

5 evidence, I mean is this essentially the

6 conceptual piece you were talking about

7 earlier that you have to really be able to

8 provide the evidence for the composite

9 conceptually and then the more empiric

10 assessment winds up in the next criteria

11 outside acceptability where you actually show

12 the data on reliability and validity for the

13 composite?

14 DR. DE LONG: Can I have some

15 clarification about evidence? When we talk

16 about evidence, are we now talking about

17 evidence for the composite for what it is

18 doing and not for the components? Because

19 that is a whole different set of evidence.

20 DR. BURSTIN: Yes, we are talking

21 about the composites.

22 DR. DE LONG: All right.

1 DR. ZASLAVSKY: I've been
2 grappling with this question that Patrick
3 posed of what the bar is for a composite which
4 didn't have an immediate answer. And I think
5 I was trying to figure out what the bar is for
6 something which isn't going through the
7 composite process. And it doesn't in that
8 section anyway say anything about showing that
9 it is useful for a particular purpose. It
10 just says it has to be a measure. Maybe I am
11 missing something there.
12 DR. BURSTIN: You are absolutely
13 right. Useful is really about usability.
14 That is a different criteria.
15 DR. ZASLAVSKY: Yes, and usability
16 doesn't actually necessarily imply usefulness
17 either.
18 DR. BURSTIN: Actually now
19 usability and use which is intended to imply
20 usefulness as it has been changed.
21 DR. ZASLAVSKY: But anyway one
22 place I came to is maybe we do have a higher

1 standard for a composite to get an NQF seal on
2 it. Anyone can take a bunch of numbers that
3 come out of measurement processes that have
4 been validated and so forth and throw them
5 together any way they want to and put it on
6 their reports and maybe even get paid for it.
7 But I don't think that the fact that they
8 bring that in front of NQF and the components
9 are all okay necessarily means that NQF wants
10 to say anything, give any kind of approval to
11 that.
12 I think that there this additional
13 step of creating the composite that NQF is
14 being asked to approve and that it is
15 reasonable for us to ask that there actually
16 be value added in that step as evidenced by
17 there being thought about what conceptually it
18 is getting at, what its purpose is and the
19 appropriate kind of evidence to meet the
20 standard required for that purpose.
21 So I feel okay about having these
22 additional requirements which go a little

1 beyond what we do with the individual
2 measures.
3 DR. DUNTON: Can we step back to
4 the purpose discussion for a minute? If we
5 have to have measure that are for all
6 purposes, and in usability we have to describe
7 how that works, can we narrow it down to one
8 into such a statement for a specific
9 composite?
10 DR. BURSTIN: You know again, this
11 is really in a different section. This is
12 about is this important to measure and report.
13 So I think it is fair game for the developer
14 to put forward their conceptualization that
15 this measure be especially important for the
16 following uses.
17 But again, that doesn't mean that
18 measure will only be endorsed for the specific
19 uses, I guess.
20 I would be curious David as you
21 think about, just because you have been
22 through this, is you think about the

1 individual CABG measures you have already
2 developed and then you think about the CABG
3 composite. If you were filling this out, what
4 would you say that would be higher? I can
5 tell you are smiling already. I mean to me,
6 that is the question. Is this something
7 substantial or is this something that sounds
8 like a little mom and apple pie?
9 DR. SHAHIAN: Well this is a
10 little scary, I think you reading my mind
11 because I was thinking about the CABG
12 composite and I think it is probably going to
13 be true of many composites.
14 There is an incredible amount of
15 evidence out there for the individual
16 components of the CABG composite and there are
17 zero evidence per se that a composite of CABG
18 measures makes any difference.
19 So the evidence was solely at the
20 level of the individual domains and measures
21 but not at the level of the composite. And I
22 suspect that that is going to be true in many

1 cases because we don't have a lot of testing
2 on composites. Is that what you were getting
3 at?
4 DR. BURSTIN: Well is it really
5 that it is maybe evidence is again we are
6 trying to pound this square peg into a round
7 hole. Are we really talking about evidence
8 for the composite or are we saying maybe it is
9 really impact? So what is the added impact of
10 having these measures in a composite versus
11 individual? Maybe it is evidence -- we are
12 really talking about evidence for the measure
13 focus. Evidence, I am not quite sure it is
14 the right --
15 DR. SHAHIAN: And in the case of
16 the CABG composite the reason we devised it --
17 well there were many reasons. One is that it
18 is increasingly difficult to distinguish
19 levels of performance based on mortality
20 alone. So that is number one.
21 Number two, there was when we
22 developed this five or six years ago an

1 increasing realization that quality
2 measurement should be multi-dimensional. And
3 we had one very narrow dimension of quality
4 that we were measuring. And this was a way to
5 incorporate mortality, morbidity, process
6 measures.
7 And then number three was consumer
8 interpretability.
9 So there were many reasons that we
10 did it and absolutely no evidence prior to the
11 introduction of the composite that it was
12 really a good thing.
13 DR. BURSTIN: And to me those
14 three are quite strong conceptual reasons why
15 we would have a composite. Maybe it is really
16 a conceptualization rather than evidence.
17 DR. ZASLAVSKY: The nature of
18 evidence is pretty broad because we have a lot
19 of alternative conceptualizations. So the
20 conceptualization here is maybe that these are
21 all things which are either measures of
22 outcome that affect patient well-being for

1 which there is evidence that the processes are
2 things that contribute to those outcomes.
3 So that is an offset of arguments.
4 It is not a set of the empirical exceptions so
5 as far as you refer to the empirical evidence
6 that the processes have contributed to
7 outcomes. But it is information that some of
8 them put together and say this is a reason for
9 this to be a composite, rather than just
10 saying I group together ten things arbitrarily
11 and say put a label on them.
12 DR. KAPLAN: To me this is still
13 winding around the issue of purpose. Because
14 if collectively these things are telling you
15 something new than they would tell you
16 individually, it is a different purpose you
17 are putting them to.
18 So now I want to evaluate
19 physician performance or I want to evaluate
20 the hospital performance on a construct I
21 could measure individually but collectively,
22 these things tell me something more robust.

1 And that new whatever, you can call it a
2 higher order construct, you can call it a
3 robust composite. You can call it something
4 but it is something else that hasn't been,
5 that these individual components don't tell
6 you. This new collective enterprise, whatever
7 construct, whatever you are calling it, the
8 new higher order thing is telling you
9 something different and it is a new purpose.
10 Now you are putting these things to a new
11 purpose and the purpose is blah, blah, blah,
12 blah, blah and here is why that is important,
13 if you are leaving it to the impact.
14 That is important because we don't
15 have right now a good measure of this new
16 blank to estimate whatever it is we are trying
17 to estimate.
18 DR. CHASE: So --
19 DR. BURSTIN: I agree with whatever
20 you say except the word purpose is throwing
21 me. That's all.
22 DR. CHASE: So can I -- I just

1 want to devil's advocate on this. We talked
2 a lot about how this would be used but is this
3 one ever going to screen anything out?
4 DR. BURSTIN: That's what I was
5 asking.
6 DR. CHASE: Can somebody give me
7 an example of where you wouldn't be able to
8 just for just about anything? Because again,
9 at some level it is just I am putting it
10 together so your point earlier, so consumers
11 will find it easier to see and to use.
12 And when you take many things and
13 put them into one, unless you go through the
14 other pieces where they are invalid, those
15 individual pieces or invalid or one of them
16 doesn't add to it, I am just --
17 DR. KAPLAN: I guess I would have
18 said what are you measuring. If I am
19 measuring physician performance, is this a new
20 measure?
21 I mean you can add up everything.
22 Don't limit it to the whatever 50 measures of

1 safety you have or whatever. Add up
2 everything NQF ever endorsed ever and what
3 have you got? You know, that is ridiculous.
4 You can't start at it that way. You have to
5 have some construct you are trying to
6 estimate.
7 So what are you trying to measure?
8 And then does this new composite thing reflect
9 that better than individual elements do?
10 DR. ROMANO: Yes, I might argue
11 that if people are really forced to describe
12 their thinking here clearly, that it will open
13 them up. It will at least foster some robust
14 discussion in steering committees that may
15 lead -- for example so if we are talking about
16 diabetes care, not to pick on you
17 specifically. But so what is the concept
18 behind -- is optimal diabetes care? Is that
19 the measure? So what is the concept behind
20 that measure? So you could say well this is
21 to facilitate consumer decision-making. But
22 then I might say well if you want to

1 facilitate consumer decision-making, getting
2 back to Liz's argument, shouldn't that be done
3 in a way that encourages consumers to lower
4 their risk to improve their outcomes? And
5 therefore isn't the implication of that, as we
6 get later into the evidence, isn't the
7 implication of that that a variety of measures
8 should be included in a way that is all
9 correlated with diabetes-related outcomes.
10 So it is not so much that people
11 would reject the rationale is that people
12 would then say well the construction of the
13 measure may not be fully consistent with that
14 rationale.
15 DR. CHASE: So the diabetes one I
16 think fits here well in the sense of part of
17 the argument with that one is those individual
18 components getting all of the components are
19 not just additive. It is they interact with
20 each other so if your blood pressure and your
21 LDL is in control, there is some evidence that
22 you are going to be better off than just a

1 patient with LDL control only or just blood
2 pressure control. We don't have to argue the
3 veracity of that now. But I mean I can see
4 where there are many cases where you would say
5 absolutely makes sense to have a composite.
6 I was trying to find the case of where you
7 would say it doesn't. There shouldn't be
8 composites unless you can actually show some
9 argument about again why it makes sense to put
10 them together and that is all we are asking.
11 DR. BURSTIN: Or maybe taking the
12 example where we have actually looked at
13 measures before that didn't make it through
14 where you put together a whole lot of topped
15 out measures and you still have got a topped
16 out measure. Is that really adding value?
17 Maybe it does go back to whoever
18 said it, but maybe part of this is actually
19 weaving in the what are you trying to measure
20 better than the individual elements on their
21 own do? That goes to some of what I think
22 David listed off. Maybe that is part of the

1 way to structure it because it has got to be
2 better.
3 Let's just try the higher bar.
4 Why is it better than simply taking the
5 individual measures? And obviously I think
6 the real tough part is going to be when we get
7 to the testing. So you probably I think --
8 DR. ZASLAVSKY: Patrick had a good
9 reformulation. The rationale isn't to make it
10 easier for consumers to look at it, it is to
11 make it easier for consumers to be informed by
12 it. So the composite has to be informative.
13 It has to be able to convey valid information,
14 which is not just a hodgepodge of stuff thrown
15 together. It has got to have some thought
16 behind it that this is a good thing for them
17 to see.
18 DR. ROMANO: And the implication
19 then is that it sets up the next stage, which
20 is evaluating the evidence because the
21 evidence then is evaluated in the context of
22 the developer's stated purpose and in fact is.

1 DR. BIRKMEYER: That's right. I
2 was just going to say the same thing that I
3 view 1d as not a screening tool to identify
4 applications, this shouldn't be here, but a
5 way to reinforce what the primary purpose is
6 to make it easier for the reviewers to judge
7 the ultimate value.
8 DR. ROMANO: Okay, so given that,
9 so there will be, obviously rewording that I
10 guess NQF staff will work on and we may
11 discuss that in a subsequent conference call.
12 So anything else that we should
13 discuss in the context of evaluation criteria
14 and one here for importance? One thing maybe
15 that struck me in looking through this is that
16 1c becomes a bit difficult to answer in the
17 context of a composite. 1a is about is it
18 high impact. That is usually sort of a
19 qualitative argument that is fairly easy for
20 people to make, although sometimes people fail
21 in it.
22 1b is about variation. That is

1 usually empirically demonstrated with in this
2 case the composite measure as a whole showing
3 the composite has performance variation,
4 opportunities for improvement.
5 But 1c is a bit awkward because
6 some of our composites actually combine
7 process and outcome measures. So how would
8 people answer 1c for those types of
9 composites?
10 DR. BURSTIN: I think we said
11 earlier they would have to look at the
12 individual components evidence.
13 DR. ROMANO: Their 1c wouldn't
14 apply then.
15 DR. DUNTON: Well just add a
16 category for both.
17 DR. ROMANO: Well should -- let me
18 -- I think it was Karen posed this question.
19 Should there be for all measures, not just
20 self-declared composite measures, should there
21 be a 1d statement that developers are required
22 to make about the purpose or objective of the

1 measure? Forget composite. Not really, there
2 is a description.
3 DR. DUNTON: Okay, it's a good
4 point.
5 DR. ROMANO: What do people think?
6 Should this be something that is required of
7 every measure?
8 DR. DUNTON: It is there in 1b,
9 really.
10 DR. BURSTIN: I was going to say
11 that.
12 DR. ROMANO: It is implied in 1b.
13 DR. BURSTIN: It would be fine to
14 have that explicit and then the additional
15 burden for composite is and how is that better
16 than the individual ones. That is fine. We
17 can consider that.
18 But could we talk about are we
19 still on -- and we talked about this earlier
20 that we did think that for the components of
21 the composite that they needed to be evidence-
22 based. So the evidence for the measure focus

1 should be there, particularly also to allow us
2 to then compare existing measures in the
3 harmonization issues.
4 DR. BIRKMEYER: But again there
5 the evidence means that there is either
6 evidence of good performance as a stand-alone
7 measure or evidence that it contributes to the
8 performance of the composite as a whole.
9 DR. BURSTIN: No, this isn't
10 evidence for the measure focus. This is
11 literally the quality, quantity and
12 consistency of the evidence for the measure
13 focus. Is there evidence that blood pressure
14 of 140/80 is the right number, if it is one of
15 the components?
16 DR. KAPLAN: When you get new
17 measures, something that is actually going to
18 make the composite more robust and there is
19 good expert opinion that that is what is going
20 to do. But there isn't good empirical support
21 for it but the measures developers can create
22 a rationale such that you are adding things

1 that actually reflect whatever it is your
2 performance at the physician level,
3 performance at the hospital level, whatever it
4 is you are trying to measure. These things
5 are conceptually very good contributors to
6 this, we think they are. Are you going to
7 stifle, are you going to cause problems here
8 in creating composites that are better and
9 more robust by limiting it to an evidentiary
10 base for some different purpose or some
11 different level?
12 DR. BIRKMEYER: I thought we
13 talked about this earlier at length.
14 DR. BURSTIN: I did, too. I
15 thought we had actually when we had this
16 discussion -- maybe I am off base but I
17 thought when I talked about this earlier, we
18 did say that the components within the
19 composite should pass the evidence test, I
20 thought. That we weren't going to require
21 them to have individual testing and they could
22 definitely be not reliable on their own but,

1 personally, as a clinician I wouldn't feel
2 very comfortable that there is measures within
3 a composite that are not evidence-based. I
4 mean we are going to get huge push back on
5 that. Evidence, not that it adds to the
6 composite but that evidence backed,
7 particularly if it is a clinical issue is
8 evidence-based, unless it is an outcome, for
9 which case you just need a rationale for why
10 it is appropriate. It is more so on the
11 process side that I think it is an issue.
12 DR. BIRKMEYER: On the process
13 side I can see that this is the discussion
14 that we had earlier with regards to the
15 example that Sherrie had around a clinically
16 credible measure that if you take it out, it
17 just deflates sort of the oomph of the broader
18 measure.
19 DR. ROMANO: Okay so if I think
20 what I am hearing is that with respect to 1c
21 and this idea of the evidence base according
22 to the type of measure, that if it is

1 composite that includes process measures, then
2 each of the processes within that composite
3 should meet the evidence criteria. Whatever
4 it is.
5 So each of the components within
6 the composite should meet the criteria that
7 are relevant for that component.
8 DR. BURSTIN: Yes.
9 DR. ROMANO: Sherrie says no.
10 DR. KAPLAN: Well not necessarily
11 for the new purpose you are putting it to.
12 Because there may not be any evidence that
13 that contributes to the new purpose, just like
14 the blood pressure example is important at the
15 patient level. We know that. But for
16 estimating physician performance, it doesn't
17 contribute.
18 So it depends --
19 DR. ROMANO: You are talking about
20 evidence for a purpose.
21 DR. KAPLAN: For a purpose, right.
22 DR. ROMANO: She's talking about

1 --

2 DR. KAPLAN: That's what I'm

3 trying to clarify.

4 DR. ROMANO: -- rationale sort of.

5 DR. BURSTIN: And that is what 1c

6 is. It is evidence for the measure focus.

7 DR. KAPLAN: All right.

8 DR. ROMANO: Okay, so are we okay,

9 then? If the evidence for the measure focus

10 is is it actually better to have a blood

11 pressure of 140/90 than to have a higher blood

12 pressure?

13 DR. BURSTIN: Right.

14 DR. ROMANO: That is an

15 intermediate outcome measure.

16 DR. BURSTIN: Yes.

17 DR. ROMANO: Currently, NQF would

18 require evidence from clinical studies that

19 that is a good thing and that should still be

20 required if it is included in a composite.

21 Right?

22 DR. BURSTIN: Yes.

1 DR. ROMANO: Okay.

2 DR. BURSTIN: What about the gap
3 or variation? Gap in care or variation, would
4 you require that the individual components
5 have a gap in care or variation? You would be
6 fine with topped out measures in a composite
7 if justified?

8 DR. CHASE: Well we gave the
9 examples where maybe for -- you might include
10 it where it is important for patient
11 communication. We brought that up as an
12 example where there is not a lot of variation
13 but you want patients to still know that that
14 is an important thing to do.

15 DR. BRATZLER: This is Dale. So I
16 think you have to be a little bit cautious
17 about topped out measures that don't
18 discriminate. Particularly, it gets to some
19 of the experience we have had with the all-or-
20 none measures. But if you have topped out
21 measures particularly that have a big
22 denominator, they can make your composite not

1 particularly valid. So you just have to be
2 cautious about including topped out measures.
3 DR. KAPLAN: This is Sherrie.
4 There is an old saying in measurement science:
5 you don't measure what doesn't vary. So you
6 wouldn't want to measure -- in the old days
7 you wouldn't want to measure diversity using
8 gender in the VA. But now the reverse is not
9 true, however. For floor effect problems,
10 things like maternal mortality. If it
11 happens, it is so bad that you need to include
12 it, even though the variability is so limited
13 that you are not going to be able to use it
14 alone. And this is what I think we were
15 talking about before. It is insufficient by
16 itself to constitute a quality indicator but
17 collectively it could contribute to an overall
18 quality indicator because when it happens, it
19 is so terrible. So we wouldn't want to put
20 the same criterion on a floor effect problem.
21 DR. ZASLAVSKY: So I think that
22 means a modification of 1b for the measures

1 going into a composite.
2 DR. BURSTIN: And I guess it
3 depends on what is the modification. I am
4 hearing, tell me if I am hearing correctly,
5 that in general you agree there should be a
6 gap but there may be extenuating circumstance
7 that perhaps you could justify inclusion of a
8 measure as part of a composite. But I think
9 it would require some justification. Does
10 that sound fair? Okay.
11 DR. ROMANO: Yes, I mean it is
12 also important to keep in mind, I mean Dale
13 raised an important point but that can be
14 dealt with through appropriate weighting. In
15 other words, if there isn't undue weight put
16 on the topped out components of a composite,
17 then they can be retained without skewing the
18 overall results of the composite, if it is
19 important to do so for conceptual reasons.
20 DR. ZASLAVSKY: I actually meant
21 to refer to 1a, high impact.
22 DR. ROMANO: Yes, I think that --

1 DR. ZASLAVSKY: You might want to
2 soften that up. I think we have a real
3 problem that you combine with a lot of other
4 things into a composite in an appropriate way.
5 DR. ROMANO: I think we actually
6 agreed 1a does not apply to individual
7 components. Right? 1a only applies to the
8 composite as a whole.
9 DR. BURSTIN: Yes.
10 DR. ROMANO: So 1a applies clearly
11 to the composite as a whole. 1c still applies
12 to individual components and 1b, as I am
13 hearing were somewhere in-between. There are
14 circumstances.
15 DR. BURSTIN: Got you.
16 DR. DE LONG: So I do think it is
17 going to become relatively cumbersome to keep
18 track of all of the topped out measures. I
19 mean we are expanding at a fast rate here.
20 And even if they make incredible sense, they
21 are going to be taken for granted. I mean,
22 they are automatically performed so they are

1 not performance measures.

2 DR. ROMANO: So I mean that is

3 where people argue for all-or-none scoring,

4 for example, that is a checklist and people

5 should do everything on the checklist and if

6 they miss anything on the checklist, it

7 indicates a bad system of care.

8 We could argue about that but that

9 is a rationale that is out there.

10 So let's move on to criterion 2,

11 scientific acceptability. And scientific

12 acceptability currently has a number of

13 components. 2a has to do with the definition

14 or specification of the measure, that is just

15 very clear how it is defined and specified so

16 that it can be implemented. 2a has been

17 adapted for composite measures, basically to

18 include components of how the composite is

19 constructed. This seems reasonably

20 straightforward. Any arguments about 2a, what

21 should be added or subtracted from 2a?

22 DR. SHAHIAN: I think it is

1 actually quite well written. I like it.
2 DR. ROMANO: Okay. So moving on
3 then to 2b. 2b is about reliability testing.
4 It is framed in terms of the repeatability of
5 the measure results when assessed in the same
6 population, in the same time period. And of
7 course it references Footnote 8 which is about
8 examples of inter-rater or intra-rater
9 reliability, internal consistency, reliability
10 for multi-item scales, test reliability for
11 survey items.
12 So how does reliability testing
13 differ for composites?
14 DR. SHAHIAN: We have the whole
15 additional issue of inter-item reliability,
16 which we don't really talk about here.
17 DR. ROMANO: Well I mean I guess I
18 would argue based on our discussion this
19 morning that it may not matter. In other
20 words if you are coming in with what you call
21 a single measure from a CAHPS survey about
22 physician patient communication, then you are

1 going to have to show the internal consistency
2 reliability of that domain measure based on
3 the construction of the survey. And
4 similarly, if you are framing it as a
5 composite, you are going to be showing the
6 same thing.
7 DR. DE LONG: So what does it mean
8 to show? I mean it seems to me that if you
9 are going to use something to rate performance
10 then you should demonstrate in some manner
11 that you get the same ratings if you use it
12 on, for example half of your data versus the
13 other half. There has to be some consistency
14 in the way this measure performs.
15 DR. ZASLAVSKY: Generally if you
16 have done that for each of the components of
17 the composite, then you can deduce that for --
18 especially since usually the different
19 components of the composites often will be
20 independent sources. If they are not, if you
21 are taking two things off of the same survey,
22 then you have to do the analysis where you put

1 them together. But in any case, the
2 mechanisms for calculating that reliability
3 estimate is going to be similar for the
4 composite. So that is from the original --
5 DR. DE LONG: I would think that
6 it would depend on the weighting of the
7 individual components.
8 DR. ZASLAVSKY: Well it might
9 depend on the weighting of the components. It
10 might depend on the relationship about the
11 measures. So it does require an analysis but
12 there is nothing terribly different from that
13 analysis from what you would do with a single
14 measure that was a combination of different
15 diamonds.
16 DR. ROMANO: Well so I guess where
17 we get into some trouble here possibly is that
18 this reliability concept is operationalized
19 currently in different ways.
20 So for outcome measures, the way
21 it is often operationalized is that the
22 measure score -- is about the precision of the

1 measure score, basically the imprint, if you
2 will, of the provider physician, the hospital
3 in the case of the AHRQ measures. So we
4 basically justify reliability based on
5 demonstrating the hospital imprint, or in your
6 studies the physician imprint, not based on
7 internal consistency reliability.
8 So is everybody still okay with
9 that? In other words that depending on what
10 people have said in Section 1 about the
11 conceptual framework for the composite, that
12 may lead in different directions in terms of
13 the reliability measures that are presented.
14 DR. KAPLAN: Yes, I mean it
15 depends on the purpose you are trying to put
16 it to and even the levels of reliability will
17 tolerate -- I mean reliability is -- the
18 question I was struggling with should NQF
19 require standard reporting out of a kind of
20 standard error of measurement or something
21 that says here is the precision of this
22 estimate for this purpose. Because for

1 example, in the certification process, ABIM
2 really need -- you have to have a fairly, a
3 really high bar of reliability because they
4 are going to flunk somebody. So for that
5 purpose, you really want to make sure that the
6 estimate is very high. For big group
7 comparisons, like I am going to compare
8 specialists to generalists or somebody to
9 somebody, large groups of folks, precision of
10 the estimate may not have to be that big.
11 So if we are going to float this
12 business about composites and purpose, maybe
13 we should talk a little bit about what the
14 tolerance is around error. You know, what are
15 the consequences of making a mistake and what
16 kinds of error can we tolerate?
17 Composites usually, you know
18 falling on what Alan was talking about,
19 composites usually buy you better precision.
20 But usually with a composite you get
21 improvements in precision, not reductions in
22 precision.

1 DR. CHASE: Except I am worried
2 about that sometimes you get improvement
3 because you make assumptions about that the
4 denominator is the same. I mean one of the
5 things I worried about when we construct
6 composites you take a prevention on an entire
7 population and we do it from how many of the
8 patients got everything they were supposed to
9 but in reality the test is really -- I mean
10 men don't get cervical cancer screening. So
11 right there the real denominator is smaller.
12 And then we just to make it easy we just
13 assumed that the denominator is the full
14 thing. And I don't know that it makes a
15 difference probably practically but I do worry
16 that we should be paying a little bit of
17 attention when we do composites that we are
18 looking at the reliability related to how the
19 composite is put together, whether the
20 denominators make sense.
21 DR. ROMANO: If there are no other
22 comments on reliability, we can move to

1 validity.

2 2c is about validity testing to

3 demonstrate that the quality of care provided

4 distinguishes good and poor quality. And

5 there are various levels or approaches to

6 validity that are allowed in the measure

7 evaluation criteria.

8 2b.1, 2b.2, 2b.3 -- so 2b.1 is

9 about capturing the target population. 2b.2

10 is about the accuracy of the score and

11 inflecting quality and 2b.3 is about the

12 exclusions.

13 So any comments -- oh, and what is

14 2b.4? Oh wait, disparities is in here, too.

15 DR. SHAHIAN: Are you in Table 4

16 now in the other document?

17 DR. ROMANO: I am looking at the

18 measure evaluation criteria table along with

19 this. So 2b or validity is broken down into

20 sub-components of validity.

21 DR. BURSTIN: Right, page 11 of

22 the other document.

1 DR. ROMANO: Page 11 of the other
2 document.
3 DR. SHAHIAN: It is actually b sub
4 1, 2, 3, 4, 5. Right?
5 DR. ROMANO: Correct. Right.
6 DR. SHAHIAN: Okay.
7 DR. ROMANO: Yes. Okay, so if you
8 look at the left-hand column on page 11 there,
9 2b.1 is specifications consistent with
10 evidence; 2b.2, validity testing for data
11 elements or the performance measure score;
12 2b.3, justification of exclusions; 2b.4,
13 justification of risk adjustment; and 2b.5
14 identifying differences in performance; and
15 2b.6 comparability of multiple data sources.
16 So issues in how these differ for
17 composite measures.
18 DR. BRATZLER: Patrick, this is
19 Dale. So again the denominator I think
20 eventually comes up here, too. In your
21 composite, if you have a measure with a large
22 denominator, it will definitely have a bigger

1 impact on overall performance of the
2 composite, depending on the methodology and
3 particularly if you don't weight it.
4 So certain performance measures,
5 you know, the composites may look like they
6 are performing relatively well if you have a
7 large denominator for one of the measures that
8 has high performance and other measures that
9 may have smaller denominators with much lower
10 levels of performance.
11 So without weighting, the
12 denominator may affect the validity of the
13 measure.
14 DR. KAPLAN: Can I ask a question?
15 The validity -- the purpose of the composite
16 measure estimates some collective that is not
17 represented better by individual components.
18 So by definition you are measuring something
19 different or somewhat different. So validity
20 answers the question are you measuring what
21 you think you are measuring.
22 So in that sense, the evidence

1 that is referred to in 1c isn't the right
2 evidence. It is evidence at the patient level
3 but it is not evidence at this level. So when
4 you talk about validity testing, I think I
5 would appreciate some clarification about what
6 you mean by are you measuring what you think
7 you are measuring if now you are creating some
8 new collective of things that together are
9 something else.
10 DR. ROMANO: Exactly. I think
11 that is the point. I mean the evidence that
12 we were talking about in 1c again is about the
13 evidence about the components, not the
14 evidence about the overall composite.
15 So this is where we have to
16 demonstrate that, speaking as a developer now,
17 that we are actually measuring what we claim
18 we are measuring. And how do we do that?
19 These forms are difficult to fill
20 out and when you get into these individual
21 components, they don't seem to pertain,
22 necessarily, to composites. I mean exclusions

1 what does that mean in the context of a
2 composite because every measure that is part
3 of that composite will have its own
4 exclusions. But it is not -- that doesn't
5 tell us about the performance of the
6 composite, the validity of the composite as a
7 whole.
8 DR. BURSTIN: Although we have
9 seen exclusions at the composite level as
10 well. So not at the individual component
11 level but actually only at the composite.
12 Patients who never make it into the bundle,
13 for example. The resuscitation over sepsis as
14 an example.
15 DR. BIRKMEYER: Well I think this
16 criterion is going to be easier for some
17 composite measure issuers than others. Those
18 that have composite measures that are derived
19 against some empirical standard and we talked
20 about this before the leapfrog survival
21 predictor, you could easily assess the extent
22 to which that measure does better or more

1 poorly against like other measures of
2 mortality.
3 If you took the composite measure
4 for CABG by STS, which is basically kind of a
5 four-part equally-weighted piece of mortality
6 and processes of care and a few other things
7 that are all kind of measuring different
8 things, you would have no way of judging
9 whether it measures what you think it is
10 measuring empirically by the same way that you
11 would in other context.
12 DR. ROMANO: So in that case, the
13 validity would be intrinsically based on the
14 validity of the individual components and the
15 conceptual framework that they all belong
16 together.
17 DR. BIRKMEYER: Face validity,
18 too.
19 DR. ROMANO: Face validity.
20 DR. KAPLAN: But so for example, I
21 am trying to estimate physician performance
22 and I want to be able to attribute whatever

1 care is being provided to an individual. I
2 could say well I am only going to apply this
3 measure to people who the doctor has seen at
4 least twice in the last calendar year because
5 otherwise, I am attributing this care to a
6 provider when that is really -- that isn't the
7 primary provider of this patient's care.
8 So from the exclusion standpoint,
9 that might be a very reasonable thing to do.
10 But then I am still stuck with am I measuring
11 physician performance? Am I measuring what I
12 think I am measuring? And how are you going
13 to tell?
14 And so doctors who provide good
15 diabetes quality should do what? You know,
16 should provide other kinds of quality, have
17 lower overall something rates? What should
18 doctors -- so that is how you tell if you are
19 measuring what you think you are measuring.
20 You either get construct validity -- you have
21 no criterion validity, so you can't use that.
22 But at least you should have some idea and if

1 you haven't already tested it, a direction, I
2 would think, Helen, might be a direction to
3 go, at least point us in a direction. If you
4 don't have good evidence now, at least tell
5 something about how you are going to evaluate
6 what you think you are measuring going
7 forward.
8 And people who are developing
9 measures should be able to tell you at least
10 something along those lines.
11 DR. DE LONG: And that relates to
12 the comment about the STS measure. Because if
13 it truly is a valid measure, then as time goes
14 on complications, the individual complications
15 should go down. If it is used for quality
16 improvement, mortality should go down. That
17 measure should be going up. And those should
18 correlate as time goes on.
19 DR. BIRKMEYER: But those comments
20 are no more true of the composite as they
21 would be applied to the components.
22 DR. DE LONG: Well, it includes

1 the process measures. And if we are driving
2 up those process measures, are we seeing the
3 whole profile improve?
4 DR. BURSTIN: This is again an
5 issue for us about individual measures as well
6 as well as composites. It is often hard to
7 figure out what the gold standard is against
8 which to compare to know that you have got a
9 valid indicator.
10 So I don't know that I see
11 anything unique and different about
12 composites, beyond what is written here.
13 DR. ROMANO: Yes, I think what we
14 heard is that there may not be criterion
15 validity, for example, because we are talking
16 about a measure -- like let's say we are
17 talking about outcome measures.
18 So if we are talking about an
19 outcome measure of a particular type of post-
20 operative complication, then we can present
21 evidence of criterion validity based on some
22 gold standard of medical record review or

1 whatever. But if we are then putting together
2 a bunch of those measures into some kind of a
3 composite measure of patient outcomes, then
4 either we have to fall back on the individual
5 components and say that the individual
6 components had criterion validity and
7 therefore the composite does or we have to use
8 a different validation framework and say well
9 this composite is valid because it predicts
10 the future outcomes of the patients.
11 And so I have some other evidence
12 that I am going to use to show that this in
13 fact predicts which hospitals or which doctors
14 will provide better care in the future or
15 better long-term outcomes.
16 DR. KAPLAN: Yes, see I think it
17 is different from the individual component
18 measures because the evidence base is
19 attributable back to patients and what happens
20 to patients over time. But those measures
21 aren't necessarily a reflection of physician
22 performance or an individual physician's

1 performance. It could be a collective of
2 physicians' performance but I think the
3 evidentiary base for using it now to reflect
4 physician performance as opposed to good
5 health outcomes for a patient, is a different
6 -- that is a different measurement task and it
7 needs a different kind of support.
8 DR. BURSTIN: I think I could
9 probably have the exact same argument about
10 some individual level measures as well. I am
11 just trying to keep us on task. I agree
12 completely those are really important
13 conceptual issues. I just don't know that
14 they are any different for a complex
15 individual measure versus a composite. We
16 have just as many issues with those kinds of
17 things for an individual intermediate outcome
18 for most docs, too or clinicians at all.
19 DR. ROMANO: Well I guess the
20 question is just that developers should be
21 asked to clarify whether their evidence of
22 validity comes from the validity of the

1 individual components or whether they are
2 making some broader argument that is based on
3 the validity of the composite and testing the
4 validity of the composite through construct
5 validity or possibly criterion validity or
6 something else.
7 At the end of the day, steering
8 committees can decide what is acceptable and
9 what is not acceptable but I think the idea
10 would be just to force that decision point.
11 Because if the developer is saying I don't
12 have any evidence about the validity of this
13 overall concept, aside from face validity, it
14 makes sense to put all these things together,
15 then it forces people to look at the
16 individual components and to put more
17 attention to whether the individual components
18 are valid. And at the end of the day, they
19 may decide that despite that, they are still
20 not totally convinced that the composite is
21 valid.
22 DR. BURSTIN: So does that go back

1 to the point we were talking about earlier,
2 perhaps that you would give, it would be
3 acceptable to have validity of the individual
4 components but you might get higher points if
5 you actually have validity of individual
6 components and validity of the composite?
7 Would that be a higher level of a
8 pass on validity, for example?
9 What if you only had validity of
10 the composite and not the -- that was the
11 third one. Sorry, I couldn't help myself.
12 You are on a roll. What if you only had
13 validity of the composite but not validity of
14 the individual components?
15 DR. CHASE: Well again, I think
16 that is only a problem when somebody is
17 questioning whether all the components are
18 necessary. I mean if you sort of already come
19 to I think all of the components are necessary
20 and then I am testing the validity of them
21 all, that doesn't seem to be -- Great. You
22 don't need to test the individual if you could

1 actually do it. I think the problem is
2 generally you don't have, you haven't tested
3 them altogether. You haven't been able to do
4 that. And so most often I would guess you get
5 people who would bring a composite in with the
6 validity around each one.
7 But I don't think we should bind
8 this to say oh, if you can't prove both, it
9 doesn't work.
10 DR. ZASLAVSKY: If someone handed
11 me an example like this, I would scratch my
12 head and go back and once we really look
13 closely about why I didn't think that the
14 components were valid but the culmination was
15 because maybe my events for the validity of
16 the composite has to be examined more closely.
17 You know, you can have a
18 regression model that is predictive using a
19 bunch of really inane valuables and then you
20 figure out it is really because they are
21 measuring the quality of the reporting or
22 something else like that as irrelevant.

1 So I don't know. We don't need to
2 belabor this. I don't think it is going to go
3 into the criteria but it is certainly that
4 something in practice that you probably look
5 at more closely when you can't understand why
6 the composite is valid but there is some
7 evidence, there is some empirical nature.
8 DR. KAPLAN: That is like the
9 betas are significant but the model is not.
10 You end up with the individual components
11 having significant beta coefficients and the
12 whole model is not significant. So yes,
13 individual components can contribute to
14 something but it is meaningless.
15 So I think if the model is
16 significant and the individual components are
17 not, then you really are in trouble.
18 DR. ROMANO: There is this concept
19 is described in the briefing memo to a
20 balancing measures within a composite. So for
21 example if you are concerned with readmissions
22 that by focusing on readmissions you are going

1 to basically encourage hospitals to keep
2 patients longer in the hospital and basically
3 never discharge patients so they don't have to
4 worry about readmitting them, then on the
5 other hand, other people are measuring length
6 of stay and putting all the focus on
7 efficiency and get the patients out. And then
8 who cares if they get readmitted?
9 So by putting the two measures
10 together, you could argue that they are
11 balancing each other's weaknesses and leading
12 to a more valid composite measure than either
13 of the components alone.
14 DR. BURSTIN: I mean a specific
15 measure, this was when I first came to NQF,
16 was a measure Leapfrog had actually put
17 forward that looked at it was actually a
18 length of stay measure. And what they put in
19 am a balancing measure, which I think
20 ultimately got redone and isn't this way
21 anymore, but just for the sake of argument,
22 they included a seven-day readmission measure

1 in it as part of it to actually show that if
2 you are pushing down on length of stay, are
3 you actually going to then see it bubble up
4 with early readmissions. I think that is the
5 logic of it. And in fact, there is a lot of
6 concern these days as we have moved to sort of
7 bundle payments and lots of other purchase.
8 Do they need to be measures that sort of get
9 a stenting or potentially these balancing
10 kinds of measures. That is an interesting
11 argument of why you might have measures within
12 a composite that aren't going to -- would
13 never really work as a stand-alone.
14 DR. ROMANO: It would be a clear
15 conceptual basis.
16 DR. BURSTIN: Yes.
17 DR. ROMANO: Okay, so other
18 concepts on validity? Okay. So I think --
19 what is next?
20 DR. BURSTIN: Can I just clarify
21 what you are saying what you are saying so I
22 understand? So we are saying that you could

1 validity of the individual components or you
2 could have validity of the composite either.
3 And that if you do both, that is like gravy.
4 That is even better. Yes? Okay, just
5 checking.
6 DR. BIRKMEYER: But you can't have
7 neither.
8 DR. BURSTIN: You cannot have
9 neither.
10 DR. ROMANO: You cannot have
11 neither and it may be sufficient -- I mean
12 when you say it is better to have both, it may
13 be sufficient to have one without the other,
14 particularly to have validity at the composite
15 level without demonstrated validity of all the
16 individual components.
17 DR. KAPLAN: It is really hard for
18 me to do this in the abstract because -- I
19 said that backwards, by the way Alan, it is
20 like having a significant model with no
21 significant data. Sorry. But you know trying
22 to think through, Helen, what would be an

1 example where for the purpose of assessing
2 something new, creating a collective out of
3 that that had no accuracy individually that
4 now you are going to summarize and make into
5 now something that has accuracy for some new
6 purpose.
7 You know I am still struggling
8 with how that would work.
9 DR. BIRKMEYER: This isn't my
10 particular field of expertise but sort of the
11 implementation side of this can point to lots
12 of illustration where bundles of processes of
13 care, if they are all done together lead to
14 salutary effects whereby all of the evidence
15 shows very negligible effects of any one
16 thing, like UTIs or SSIs after surgery.
17 DR. ROMANO: And I think the more
18 common scenario even is where you really are
19 unable to get evidence about the individual --
20 the validity of individual components because
21 if it is a rare event and it is just not
22 feasible to assess the criteria and validity

1 of some of those components.
2 DR. KAPLAN: Right. Again, it
3 comes back -- I don't want to get tangled up
4 in evidence because this is a very theoretical
5 discussion. But it is about are you measuring
6 what you think you are measuring?
7 So adding those things up in
8 quality terms, the evidence support comes from
9 a different purpose. Now I am creating a new
10 purpose of measurement. Now I am going to
11 create a physician performance measure out of
12 this. What is the evidence that that is what
13 you are measuring is physician performance,
14 not patient outcomes or patient something or
15 other.
16 So that is where I still am
17 struggling with the composite versus the
18 individual components when it leads back to
19 the evidence that NQF is required for all the
20 individual components.
21 DR. ROMANO: 2f in the current
22 measure evaluation criteria for composite is

1 about methods scoring and analysis that allow
2 for identification of statistically
3 significant and practically or clinically
4 meaningful differences in performance.
5 Any questions or concerns about
6 that? So it is basically the same criteria --
7 the same criteria exists for individual
8 measures. So that seems fairly
9 straightforward.
10 Disparities, 2h again is the same
11 criteria I think as for individual measures.
12 DR. BURSTIN: Yes.
13 DR. ROMANO: Right? Okay. So
14 what is different for composites in the
15 current framework is 2i, j, k, and l. So
16 let's focus our remaining discussion on those
17 items, 2i, j, k, and l. And this is where
18 people have a little trouble.
19 So 2i is about that components --
20 empirical analysis showing that components fit
21 the conceptual construct; 2j is about
22 contributing to the variation and the overall

1 composite score; 2k is about weighting rules
2 that are consistent with the conceptual
3 construct; and 2l is about how missing data
4 are handled.
5 DR. SHAHIAN: I think those are
6 pretty good.
7 DR. ZASLAVSKY: I'm a little
8 uncomfortable with 2i because I think if you
9 are doing composites you are probably moving
10 to or likely to be moving in a direction of a
11 broader kind of construct for which the
12 internal consistency is not going to be as
13 high.
14 I think there is certainly
15 circumstances where you might look at it but
16 it is only one of the possible arguments for
17 creating a composite.
18 DR. SHAHIAN: Would the or
19 statement take care of that?
20 DR. ZASLAVSKY: Well I would
21 rather not see one thing highlighted there and
22 then other things being something you would

1 have to justify.

2 DR. ROMANO: Yes, I would agree

3 with that. Personally, I am comfortable with

4 the assumption that internal consistency

5 reliability has to be met or if not, there

6 needs to be justification because, as we have

7 discussed earlier in some cases internal

8 consistency reliability is just not

9 appropriate for the purpose of the composite.

10 So how do we reframe this in a

11 way that it is more inclusive in terms of

12 linking the methods that are presented with

13 the purpose of the composite?

14 DR. DE LONG: Can we just take out

15 what is in parentheses?

16 DR. ZASLAVSKY: Yes, there might

17 be some -- I don't know if there is some

18 explanatory material maybe a footnote that

19 would refer to some of the different types of

20 analysis that would be relevant to different

21 purposes but I wouldn't put it into the item

22 itself.

1 DR. ROMANO: So I guess looking
2 together at 2i and j, I think my concern would
3 be that these two items put too much emphasis
4 on the components and not enough emphasis on
5 the overall properties of the composite. So
6 is there a way to shift that methodologic
7 focus a bit?
8 DR. ZASLAVSKY: I think i and j
9 were written with a view to particularly the
10 value of a composite for improving
11 reliability. And since we are looking at a
12 broader set of purposes, that might be one
13 thing you might look at that would be one
14 reason for the composite, one support for the
15 composite but it is not other rationales which
16 would not involve that. I'm not quite sure
17 how to deal with that. It sort of makes that
18 a default the way it is written now.
19 Maybe the point should be more a
20 rationale should be given for inclusion for
21 all of the items or something like that. We
22 had a bit of a discussion about that before

1 about whether you would want to have a bias in
2 favor of more parsimonious composites when
3 there isn't an argument for including
4 everything just to make them easier to create
5 and reduce the data collection burden. But is
6 a very qualified argument. So it is a little
7 hard to formulate it as a general criterion.
8 DR. ROMANO: So is there a way of
9 taking 2i and 2 j and reframing them so that
10 it is linked a bit more like an if-then sort
11 of logic? Like if the developer says that the
12 purpose is to increase reliability, then we
13 look for evidence related to internal
14 consistency reliability.
15 Helen doesn't like that idea.
16 DR. BURSTIN: It doesn't lead to
17 consistency in our committees and it leaves it
18 up too much to the developer to make that
19 call.
20 DR. ROMANO: Well I am trying to
21 come up with a way to improve consistency so
22 that it would be clear that if the developer

1 says A, then the committee is expecting to see
2 B. If the developer says C, the committee is
3 expecting to see D. So I am actually trying
4 to see if that can be improved by tightening
5 the linkage between the measurement construct
6 and the evidence, the validity testing
7 evidence that is presented in support of that.
8 DR. ZASLAVSKY: Patrick, here is
9 another tact for 2j. What if we asked that
10 the application shows reasonable attention to
11 parsimony as a value? If that is the reason
12 for this, let's just state it as a value
13 directly and then the developer can respond by
14 saying this is why all of these items are
15 important or they can get that one and say you
16 know I could have dropped out five things and
17 it would be just as good. Is that what we are
18 trying to get at there?
19 DR. ROMANO: Feedback on Alan's
20 idea?
21 DR. KAPLAN: The way it is worded
22 now you can't do it with an index anyway

1 because each item has a zero/one probability
2 to contributing to the variants in the
3 outcome. So you couldn't even use this for
4 indices.
5 So for me, if the intent is that
6 you want to have items that improve precision
7 to the level you are shooting for for the
8 purpose you are trying to put it to and the
9 addition of items beyond that that don't
10 contribute unique variation if there is unique
11 variation to contribute to the overall score,
12 then your rationale for including them has to
13 be something other than improvements in
14 precision.
15 I didn't know the way that reads
16 if that was your intent. What was the purpose
17 of writing 2i and j, Helen?
18 DR. BURSTIN: I'm not sure I
19 remember exactly but I do think part of this
20 was because everything above it, 2a through 2f
21 was all about the composite itself at a higher
22 level. I think this really reflected the

1 concerns about the component measures. So I
2 think this was again a look -- this was why I
3 think we have had that discussion is about
4 composite level of the individual score level
5 or both. And I think the composite committee
6 last time squarely came down the side of both.
7 And so I think the question for me is are we
8 still in that same place? I'm not sure we
9 are. But I think it was to say can you also
10 justify the individual's inclusion in an
11 empiric way?
12 DR. ROMANO: So Sherrie, what
13 would you propose instead of 2i and 2j? I
14 mean I completely agree with what you said.
15 I am just not sure how to frame it in these
16 evaluation criteria.
17 DR. KAPLAN: I think I get the
18 principle that they should, that the
19 components of the composite should share
20 something in common. I think that is what you
21 are shooting for empirically. Right?
22 DR. ROMANO: They should tell us

1 something about the construct.

2 DR. KAPLAN: That they should

3 share something in common that reflects an

4 underlying construct, the latent construct,

5 whatever it is. All of the things it used to

6 represent that should at least share something

7 in common.

8 DR. ROMANO: Well they don't

9 actually have to share any variants, do they?

10 DR. KAPLAN: No.

11 DR. ROMANO: Right. Okay.

12 DR. KAPLAN: No, not at all.

13 Because if you do an index, by definition you

14 are going to limit your ability. And for

15 things like a collective measure of

16 comorbidity, it doesn't make any sense to do

17 that kind of analysis.

18 DR. ROMANO: So when you are

19 talking about sharing something, you are

20 talking about sharing something at the

21 conceptual level.

22 DR. KAPLAN: Well either -- yes,

1 either the conceptual -- they have to have one
2 of three things. One is first they have to
3 have some kind of conceptual nod from the
4 people who are experts. They had better share
5 that in common. You are measuring what you
6 think are measuring or you are doing -- your
7 measurement error isn't going to be too great
8 so that you are actually reflecting physician
9 performance or hospital performance or
10 something, one.
11 The second thing is is I would ask
12 for some kind of either plan for or supporting
13 evidence for the composite different from the
14 individual elements of it for the reliability.
15 And then I would ask for some evidence that
16 individual components contribute uniquely to
17 the overall construct, that you are not just
18 adding more things because you can measure 50
19 things about somebody's quality of care but
20 you chose the eight things that really are
21 sensitive indicators to good quality.
22 DR. ROMANO: Okay so that gets

1 back to Alan's idea about parsimony, that
2 there has been attention to parsimony and the
3 construction of the composite and that
4 therefore the components of the composite have
5 to have some justification either an empirical
6 justification or a conceptual justification.
7 If we are relying entirely on a
8 conceptual justification, presumably it should
9 be a fairly strong concept. Is that fair?
10 DR. DE LONG: So how does that
11 take us away from what is written? It seems
12 that that is consistent with what we have
13 here.
14 DR. ROMANO: Well it basically
15 erases 2i and 2j as they are currently written
16 and rewrites it in a more general context.
17 DR. ZASLAVSKY: I think the
18 concept of 2i is still pretty much there
19 except we have taken out the specific of the
20 item. But I think 2j is a very specific
21 notion of why you would include items and we
22 are just broadening it. We are saying you

1 just have to had paid attention to having a
2 rationale for including the items. It doesn't
3 have to be about reliability.
4 DR. ROMANO: I think in general
5 where we are agreed is that 2i and 2j are too
6 embedded, as they are currently written are to
7 embedded in a particular framework or approach
8 and that we have to come up with much more
9 general language that encompasses a variety of
10 different applications. The devil will be in
11 the details of the wording here.
12 DR. BURSTIN: And actually just to
13 pull from the old report because you asked why
14 that was, so they specifically had in this
15 section on scientific acceptability, several
16 approaches might be used to combine measures.
17 One approach might be the psychometric
18 approach developed, blah, blah, blah, create
19 a complex construct that is not directly
20 measurable using multi-item scales.
21 With the psychometric approach,
22 the component items are measures that

1 generally are measuring the same underlying
2 construct and should be correlated with one
3 another, although not perfectly and they would
4 be redundant. Some composite measures may not
5 reflect this classic psychometric construct,
6 depending on the types of items or measures
7 that are included in the composite.
8 When the components are not
9 correlated, the rationale and justification
10 for their inclusion must be provided and
11 appropriate analyses identified.
12 So that matches our discussion.
13 We will just have to see how that translates.
14 That is actually, from this discussion they
15 have got this wording. So we will need to see
16 how those play together.
17 DR. KAPLAN: Just to follow up on
18 that Helen, so for example, if you are looking
19 at physician performance and sort of how you
20 get to reliability at the physician level. So
21 one common way to do that is interclass
22 correlation. So you look at how much do

1 doctors, are they consistent across patients
2 in their practice and do they differ from
3 other doctors in your comparison group?
4 So that is a different approach to
5 sort of the same principle, the issues of
6 principle. But this sounds to me like I did
7 a total correlation matrix and that doesn't
8 make any sense for a lot purposes.
9 DR. ROMANO: It is also a little
10 bit confusing about whether it is a
11 reliability concept or a validity concept,
12 frankly. Because I would think of item total
13 correlations and Cronbach's alpha as being
14 reliability measures, not as being validity
15 measures but they are here under validity.
16 DR. KAPLAN: But you could an
17 exploratory factor analysis, for example, and
18 then you are sounding very similar and that is
19 often used as an evidence for validity.
20 DR. ZASLAVSKY: Or you might do
21 something like a criterion regression like
22 regression of mortality on a bunch of

1 variables that would say these are all
2 contributors to mortality.
3 DR. ROMANO: I think back to the
4 work that John did with Leapfrog. Basically
5 and correct me if I get this wrong but I
6 thought it was very clever because the idea
7 was that consumers and people acting on behalf
8 of consumers, employers, purchasers, whatever,
9 want to pick hospitals based on where is the
10 best place to go today for esophageal surgery.
11 But what we have are these data
12 from two or three years ago. And so what we
13 really want is to figure out a way to bring
14 together multiple measures to get the best
15 estimate of current performance. And that may
16 involve compositing several different types of
17 measures in order to provide the best
18 prediction, if you will, of current
19 performance to inform current decision-making.
20 So this gets back to my fixation
21 on decision-making but if the decision-making
22 framework is about helping consumers and

1 purchasers make decisions today about where is
2 the best hospital to go, then you can develop
3 a conceptual rationale and you can test the
4 validity based on how those components
5 contribute to a better prediction, a less
6 biased prediction.
7 DR. BIRKMEYER: To be fair, I
8 think we were also a little bit unique using
9 the tool of seeing how well historical
10 measures forecast outcomes in future years, as
11 a twist on the usual splits sample approach
12 but again trying to get back to what you are
13 trying to simulate or what the consumers are
14 actually using the data for and it is to make
15 a decision here and now.
16 DR. ROMANO: Okay, so let's look
17 at 2k, the scoring/aggregation and weighting
18 rules are consistent with the conceptual
19 construct. And then there is some stuff in
20 parentheses that I would disagree with. I'm
21 not sure how others feel.
22 But I guess the question is do we

1 want to indicate a preference for a particular
2 weighting scheme? I would argue in general
3 that any weighting scheme involves value
4 judgments and, therefore, equal weighting
5 entails a particular set of judgments that
6 doesn't make it any better than anything else.
7 DR. SHAHIAN: I would just say
8 that the justification for any weighting
9 scheme or lack thereof must be given.
10 DR. ROMANO: And what guidance
11 will we give to steering committees to
12 evaluate that weighting scheme?
13 DR. SHAHIAN: I think you have to
14 ask if they do choose weighting how are the
15 weights derived from factor analysis, from --
16 you know we actually in the STS we tried to
17 figure out among the various morbidities what
18 is most important to patients. We tried to
19 figure out what providers who had seen many
20 patients with strokes versus death versus
21 internal infection, how they graded the
22 relative importance of those complications.

1 Let me just tell you that in cardiac surgery
2 it is very hard to do that but I'm sure in
3 other areas people have done that, sort of
4 quality of life impact and that sort of thing,
5 expert opinion, delta, whatever. I think one
6 just has to use one of those methods.
7 DR. ROMANO: Well I like that
8 because it puts the emphasis on kind of a
9 patient-centered weighting scheme of what is
10 most important to patients, what has the most
11 impact on patients. And I really like that.
12 It would be nice to encourage more of that
13 sort of thing.
14 DR. BIRKMEYER: Well we just to
15 need to acknowledge that in the short-term
16 that a lot of those judgments are going to be
17 based on expert opinion.
18 DR. KAPLAN: Just as an
19 experiential cautionary note, anytime you mess
20 with any sort of otherwise sort of
21 straightforward activity like adding things up
22 and you move it further and further way from

1 common sense, you get harder and harder to
2 explain to people and it is less and less
3 transparent.
4 So I would like to make the case
5 for at least they better bloody well compare
6 it to what happened with a simple algebraic
7 sum or some simple add them up of criteria
8 that is such an improvement that it shuffles
9 the whole distribution around. It does
10 something else that is a substantial
11 improvement over what would otherwise be a
12 little very much easier to translate and
13 transmit measurement activity.
14 DR. ROMANO: You are favoring
15 equal weighting as a default.
16 DR. KAPLAN: I'm favoring a
17 summary of things that is easy to transmit and
18 on the face of it looks like not a
19 transformation that is going to introduce
20 hocus-pocus.
21 DR. BRATZLER: It almost comes
22 down to whether you weight them equally or

1 with regard to weight composite measures, the
2 individual components about whether you should
3 even include some of your components. I mean
4 you almost to need to make some argument if
5 something has to be de-rated, perhaps it would
6 need to be in the composite.
7 DR. DE LONG: I think it is not
8 altogether clear when we talk about equal
9 weighting because, for example, some
10 components will have fewer observations
11 involved. So do we transform them and then
12 add them equally or do we add them in equally
13 de novo?
14 So I think we are always going to
15 get into some complexities that just need to
16 be explained and rationalized.
17 DR. ZASLAVSKY: I'm going to
18 suggest something parallel to what I suggested
19 on the inclusion of items that you just
20 expressed the principle of parsimony that here
21 we should just say with due regard to
22 simplicity and presentability as well as other

1 justifications, something like that. Just
2 express what the value is and then the
3 committee is going to know they are supposed
4 to look for that and see whether there is a
5 rationale if things are very complicated.
6 DR. DE LONG: I just wanted to say
7 they should recognize that the more
8 complicated they make it, the harder it is to
9 get evaluated. So they are probably going to
10 want to make it as simple as possible anyway.
11 DR. ROMANO: I mean I guess I sort
12 of agree with what you said earlier that even
13 -- there is no avoiding complexity. And that
14 even things that seem simple aren't really
15 simple because they involved certain
16 assumptions that are pretty wild assumptions.
17 So when I see process measure
18 composites that just add together ten
19 processes and the denominator is five times
20 bigger for one of those than another one and
21 another one has five times the impact on death
22 as another one, I just wonder what the hell.

1 I mean, it doesn't have face
2 validity for me to add those up because they
3 are so different in terms of their impact on
4 patient outcomes on what really matters.
5 DR. SHAHIAN: Yes, and just to
6 support what Sherrie said about messing with
7 simplicity, after trying all the things that
8 I mentioned in the STS we ultimately defaulted
9 to equal waiting of the various components.
10 And in fact most of the literature that I
11 could find at the time including what I think
12 is the single best reference on devising
13 composite measures, at least for healthcare is
14 this OECD document by Nardo which I think is
15 great. But they all suggest equal weighting.
16 So I think we have some justification for
17 that.
18 So I think just providing a
19 justification for the approach that you do and
20 whether we acknowledge that sometimes simpler
21 is better.
22 DR. GOLDSTEIN: And I guess I

1 would second some of the things that people
2 have said that just really providing a
3 justification for the weighting scheme, I mean
4 for your health plan ratings for example, we
5 got actually lots of complaints from
6 stakeholders when we when we did equal
7 weighting. So we did spend a lot of time
8 getting input from clients and consumer
9 advocates and all different experts on
10 alternative weighting schemes. And then in
11 the end we talk about input, and it was a
12 policy call as well, and incorporated
13 weighting. And that is probably one of the
14 things that we did at least for that rating
15 system that we got the least amount of
16 complaints or concern about because people
17 generally agreed we weighted outcomes the
18 highest, process measures the least, patient
19 experience kind of falls in the middle.
20 So where people quibbled is the
21 size of the weights but I think in general we
22 moved the industry in the right direction. I

1 mean everyone agreed all stakeholder outcomes
2 ultimately is where you want to go. So that
3 should, in any composite measure for combining
4 different types of measures should be weighted
5 the highest.
6 So I think in any submission you
7 really want to understand the rationale and
8 what are you trying to do with the
9 measurement. What are you trying to drive in
10 terms of quality improvement. What is the
11 most important indicators? Maybe those are
12 the ones that get the highest weight.
13 DR. BURSTIN: How does all-or-none
14 fit in here or does it?
15 DR. ROMANO: Well presumably it
16 would require a rationale that is consistent
17 with the conceptual construct. Right?
18 DR. BURSTIN: Right.
19 DR. ROMANO: So the developer
20 would have to present a conceptual construct
21 in which all or none weighting would make
22 sense.

1 DR. BURSTIN: Right. Well I'm
2 just wondering if we need the first sentence
3 at all or do we just being the parentheses
4 with weights are determined by empirical
5 analysis or a systematic assessment of expert
6 opinion. I mean it just seems like I don't
7 know that we need to state that equal waiting
8 is preferred.
9 DR. ROMANO: Right. I think that
10 is -- I am certainly agreeing with that. I
11 mean there is some -- in place of that wording
12 there is some suggestion of again perhaps more
13 general wording saying that in general
14 simplicity is good. That doesn't necessarily
15 mean because even in the concept of equal
16 weighting is not entirely clear, as Liz
17 pointed out is what does that mean in terms of
18 how an indicator is actually constructed. Is
19 it the denominators are equal? Is it the
20 numerators are equal? Is it the standard
21 errors that are equal?
22 DR. KAPLAN: Just empirically, the

1 most robust scores are the ones that are
2 robust across weighting schemes. So you get
3 the same answer no matter what you do. So in
4 some ways this falls back to the measure and
5 how they are constructed, rather than
6 ultimately how they are weighted or not
7 weighted for a scoring scheme.
8 DR. BRATZLER: Well and again, it
9 is part of the reason we have never submitted
10 any of the composite all-or-none measures that
11 we have developed in the past and have used
12 them for performance improvement but not for
13 a calibraity. If you have one measure that
14 particularly in the classic all-or-none
15 calculation, if you will then measure it with
16 a very large denominator, when your composite
17 really ends up simply reflecting to a large
18 extent performance on that individual measure
19 and not your other measures that you may have
20 as part of this composite. So you do have to
21 worry about denominators in all-or-none
22 measures and if they are all rated equally,

1 then the composite may just reflect what is in
2 the measure.
3 DR. ROMANO: At least in the AHRQ
4 composites we have incorporated reliability
5 weighting so that the measures that have more
6 hospital level signal get more weight based on
7 the constructs that we are trying to inform
8 the market about hospital performance in a
9 particular domain. So it would make sense
10 that measures that have more signal at the
11 hospital level would better inform that
12 overall decision but might not be right for
13 all cases.
14 DR. BRATZLER: Well that certainly
15 would be the approach that CDC is looking at
16 for some of the infection measures now, which
17 is reliability rated.
18 DR. ROMANO: Okay. So any other
19 comments about scoring and weighting rules,
20 what developers should be told there? We can
21 talk about 21, which is about missing
22 component scores. Do we want to revise that,

1 delete that, add to it, clarify it?
2 DR. SHAHIAN: I wonder if we
3 should say anything specifically about the
4 management of missing scores in all-or-none
5 measures. There I think it becomes there
6 really missing data on one component of an
7 all-or-none can affect the all-or-none measure
8 in a way that it doesn't affect other sorts of
9 measures. I don't know how others feel about
10 that.
11 DR. ROMANO: Well, the same thing
12 is true for validity of components. Right?
13 So I mean in an all-or-none construction, the
14 validity of one component may drive the
15 validity of the entire composite in a way that
16 wouldn't happen with other weighting schemes.
17 DR. ZASLAVSKY: I think I agree
18 with the content of 21 but I can't parse the
19 sentence. Am I the only one who finds this
20 sentence hard to read?
21 Analysis of missing component
22 scores supports the specifications for

1 scoring/aggregation and handling.

2 Isn't there something about what

3 we want that to actually show that it will

4 eliminate bias associated with -- will

5 minimize bias associated with missing data,

6 something like that.

7 DR. ROMANO: I like that emphasis

8 on minimizing bias.

9 DR. KAPLAN: And specification.

10 They have to say what their missing data, how

11 the missing data treatment, what treatment of

12 missing data is and then how that treatment

13 minimizes bias. I would stick with some

14 language with that. I agree with Alan, that

15 is a very complicated sentence.

16 DR. ZASLAVSKY: And they should

17 tell us how much missing data there was in

18 their pilot data as well. If that is really

19 high, you have to really question the

20 feasibility.

21 DR. CHASE: And the only thing I

22 would caution about this would be not having

1 a preference for missing data isn't a reason
2 to score people low. I think many in the
3 measurement feel for example smoking status,
4 if you didn't take it, it is alright to count
5 it as not having -- you know you get a zero
6 for that.
7 So to me that isn't a measurement
8 error, as opposed to other things where data
9 just wasn't available or you didn't pick it up
10 in certain places where you should have. And
11 then how you deal with that I think is
12 important, especially because a lot of these
13 composites, as you know, would take the mean
14 of the whole or something and that adds extra
15 change to the measure that may not be fair to
16 everybody.
17 DR. KAPLAN: Helen, are you going
18 to use this? Are you going to score this?
19 Like in the Cochrane stuff, if you didn't put
20 anything in about how you treated missing data
21 you get a zero. If you put some lame thing in
22 that isn't very good but at least you told

1 people, you get a one. And then if you did a
2 really super-duper job of it you get a two.
3 So are you going to score this?
4 DR. BURSTIN: They will get rated
5 overall on the score for validity and the
6 score for reliability. So this will factor
7 into it, yes.
8 And just one last thing in here, I
9 think part of the reason this was also here is
10 some of the composites --
11 DR. ROMANO: It is not necessarily
12 a point scheme. Right?
13 DR. BURSTIN: No, it is not a
14 point a scheme but it is factored in. So if
15 is left out, we would send it back to the
16 developer to finish. It has got to be
17 complete. Yes.
18 But just one other point about
19 this. I think one of the reasons this was
20 here is we had seen some composites, for
21 example, that had assigned the mean national
22 value for example for missing data which

1 committees just didn't think were kosher and
2 make sure that is okay that that is captured.
3 DR. ROMANO: There are some
4 variance problems there.
5 So what I am hearing maybe for
6 both 2k and 2l is that we actually want more
7 specificity. In other words, we are maybe not
8 going to be prescriptive about what developers
9 must do but we are going to demand more in
10 terms of explanation and justification.
11 So in the case of missing data,
12 they should show us how much missing data
13 there is on each component and what their
14 approach was to handling the missing data.
15 As Jim pointed out, a perfectly
16 acceptable approach might be to assume it
17 didn't happen for the sake of some measures
18 but that should be explicit.
19 In other cases, they may have done
20 some imputation but if that did some
21 imputation, it better be an approach that
22 incorporates some variants and just assume the

1 same value.

2 So we will expect that to be

3 submitted as part of the process. And perhaps

4 the same for 2k that developers have to show

5 that their weighting scheme is consistent with

6 the conceptual construct. And to the extent

7 that they might have compared their scheme

8 with a simpler scheme, they should share that

9 finding.

10 So other thoughts about these

11 components? I think is it time for us to take

12 our afternoon break probably? Okay.

13 All right, well let's take a ten-

14 minute break. We will reconvene at 3:15.

15 (Whereupon, the above-entitled

16 matter

17 went off the record at 3:01 p.m. and went back

18 on the record at 3:16 p.m.)

19 DR. ROMANO: Okay, so we are

20 reconvening. Thank you, Dale, for staying

21 with us.

22 DR. BRATZLER: I am here.

1 DR. ROMANO: Okay, so now we are
2 moving on to talk about NQF measure evaluation
3 criteria three and four; three is usability,
4 four is feasibility. And here we are actually
5 doing a little last minute work because the
6 usability criteria are about to change in a
7 fairly substantial way.
8 DR. BURSTIN: It is correct on 12.
9 Page 12 is correct.
10 DR. ROMANO: Yes, right, except it
11 is so cryptic there that I asked them to bring
12 it up the full version.
13 So what is now called usability
14 will be called usability and use. And if you
15 look at page 12 of this briefing document, the
16 DRAFT Table 4, it lists very cryptically three
17 criteria for usability and use but we are
18 trying to pull up a more specific version so
19 then we can see how these would be modified
20 for composites.
21 (Pause.)
22 DR. ROMANO: Okay. Anyway, sorry

1 for the technical delay. But the two
2 additional criteria you can see 3d and 3e. We
3 can start talking about that a little bit. So
4 3d is saying that data detail is maintained
5 such that the composite measure can be
6 decomposed into its components to facilitate
7 transparency and understanding.
8 So let's --
9 MS. PAGET: Patrick?
10 DR. ROMANO: Yes.
11 MS. PAGET: Just to add a little
12 light to the afternoon. If you do a thesaurus
13 check on decompose, you get rot, decay,
14 crumble, fester, putrefy.
15 (Laughter.)
16 MS. PAGET: So if we do want to
17 stay away from that word, I think we could
18 simply say data detail is maintained such that
19 the components of the composite measure are
20 transparent. I mean, you know, --
21 DR. KAPLAN: We could use
22 disaggregated.

1 MS. PAGET: It has to have a fancy
2 word.
3 DR. ZASLAVSKY: I am going to look
4 up the thesaurus definition of transparent and
5 you are going to pull that back. Can be seen
6 through, invisible.
7 MS. PAGET: Try unpack, unravel,
8 and deconstruct.
9 DR. ZASLAVSKY: How about
10 disaggregate?
11 DR. ROMANO: Well I think the
12 conceptual problem is that we have already
13 talked about some scenarios earlier today
14 where in fact a composite is being constructed
15 of components that do not support
16 disaggregation, at least for public reporting
17 applications.
18 So is that okay? I mean
19 disaggregation may be desirable to providers
20 to see where they went wrong, so to speak,
21 within the composite. But if the component
22 completely randomly distributed, then it

1 doesn't actually inform public reporting.
2 DR. KAPLAN: I was waiting to see
3 if Helen turned my microphone off.
4 So to the extent that people are
5 going to want to know how to improve their
6 scores, they are going to want to know where
7 did I fall down. So these things, if you kind
8 of report them back out in any kind of
9 disaggregated form, I think people are going
10 to be bummed out. That is a technical term.
11 DR. ROMANO: Right. So does the
12 disaggregation have to be subject to public
13 reporting?
14 DR. BURSTIN: I think the question
15 is it could certainly be used for internal QI.
16 I mean people use all kinds of back of the
17 envelope stuff for internal QI. I guess the
18 question is, for example, if you have several
19 component QIs in some of your components that
20 you don't feel are reliable, estimates on
21 their own, you would certainly would not want
22 to use those for accountability. So I think

1 there probably needs to be some statement that
2 they should really only be used in that way if
3 they are indicated as being reliable at the
4 individual level. Beyond QI only. Does that
5 make sense?
6 DR. ZASLAVSKY: Well they might
7 not be -- yes, I guess for public reporting,
8 yes, or for payment. For QI any level of
9 detail is fine.
10 But even there in some cases the
11 components aren't meaningful at all. You know
12 like if it is an A or B type of thing. So you
13 don't want to impose too high a standard there
14 breaking down something that isn't really
15 meant to be meaningful in its pieces.
16 MS. PAGET: Well there is
17 transparency and then there is intended uses
18 for purposes of -- so could the developer be
19 asked -- I mean at minimum we want
20 transparency, I would hope, just to be able to
21 define what is making up the composite. And
22 then perhaps secondarily they can indicate its

1 uses for other purposes. I don't know.

2 DR. ROMANO: Yes, I guess what

3 does this mean in practice? Data detail is

4 maintained such that the composite measure can

5 be disaggregated. What does that actually

6 mean?

7 DR. BURSTIN: I think the intent

8 was simply that for putting forward a

9 composite measure there should still be the

10 capacity to be able to look under the hood and

11 look at the five component measure scores that

12 went into it.

13 This does seem like pretty

14 highfalutin language to just say that. And

15 maybe it is just something as simple as saying

16 that when appropriate, based on measure score

17 performance -- not measure score performance

18 but performance of the measure characteristics

19 being able to examine the individual

20 components should be encouraged for something

21 along those lines.

22 MS. PAGET: Well and if we really

1 think that we are someday using these
2 composites for value-based purchasing and
3 comparative reporting, et cetera, et cetera,
4 you have to be able to look under the hood, I
5 would think.
6 DR. ROMANO: So would anybody ever
7 fail on that criterion? I mean is that just
8 something that is expected or --
9 DR. BURSTIN: I mean well I guess
10 that is the question. I mean not to pick on
11 the AHRQ example but if you have a composite
12 that you feel very comfortable has great
13 performance at the composite level but you
14 don't have great comfort, necessarily, in some
15 of the performance at the individual component
16 level, would you always want those to be
17 reported out such that -- you know we just
18 talked about this earlier. Would you want a
19 consumer looking at a non-reliable indicator?
20 Is that what we want to do?
21 So I guess for me that is the one
22 qualification is you should really only put

1 out there what you feel comfortable is in fact
2 a valid representation of quality to consumers
3 and purchasers.
4 DR. SHAHIAN: I think the
5 providers, though, and we certainly have seen
6 situations with the STS CABG composite where
7 the providers really wanted to know or
8 challenge how a particular domain score was
9 arrived at and we can provide that to them now
10 routinely.
11 So I think at the very least
12 providers have to have the ability to get to
13 the detail level. Some may not be appropriate
14 for public reporting but at the very least the
15 providers that are being judged by these
16 measures need that.
17 DR. ROMANO: So then what I am
18 hearing is the emphasis really is on the last
19 part of this. It is on facilitating
20 transparency and understanding. And somehow
21 we need to rewrite the first part of this to
22 make it clearer that we are not -- that what

1 we want to ensure is that the data are
2 collected and composited in a way that permits
3 this disaggregation. But we are not
4 necessarily asking developers to support that
5 disaggregation for every application of the
6 measure.
7 DR. SHAHIAN: I think the ideal
8 scenario is one in which a less-informed
9 consumer can look at something simple and
10 visual like a star, a more sophisticated
11 consumer can drill down to the next level of
12 detail what is behind that rating. I don't
13 know if we want to express a preference for
14 that but multiple levels of detail are
15 available, something like that.
16 I think that various stakeholder
17 differ in how much information they can want
18 or digest.
19 DR. BURSTIN: We don't want to go
20 into that here. That is not without
21 controversy, as we have seen.
22 But I mean this is change from the

1 prior version. I did pull up the prior
2 version. The idea over there was that it is
3 critical that a composite measure when
4 reported is readily decomposable into its
5 constituent domains and individual measures.
6 This will focus and facilitate quality
7 improvement activities by providers and
8 increased transparency and understanding of
9 the measured results by all potential
10 audiences. Additionally, it should be
11 demonstrated the purpose of creating a
12 composite measure was achieved.
13 So they are actually stronger.
14 They are saying that -- and again part of this
15 was because they required that the individual
16 components had to essentially meet all
17 criteria. So in that case of course you would
18 put them out there. But if that is a
19 potential change that this committee is
20 recommending, then I think that does need to
21 be qualified.
22 DR. ROMANO: Okay, so people could

1 look at the white board or the screen. Sorry.
2 I guess I spend too much time in the
3 classroom.
4 So the current criteria or the new
5 criteria here focus on -- no this is not the
6 new criteria, are they?
7 (Pause.)
8 DR. ROMANO: There it is. There
9 it is. Okay. So 4a is about -- so what I
10 want people to do is just look at these
11 because this is what is coming down the pike
12 as of January, I guess.
13 So do these need to be adapted or
14 modified for composite measures? So 4a is
15 about accountability and transparency. And
16 the idea here is to focus on use. In other
17 words, usability is manifested by use. If an
18 indicator is really usable, then it should be
19 used. And so criterion 4a is putting forward
20 a specific criterion about the actual use of
21 a measure. Is there any reason why this
22 criterion would not apply or would differ for

1 composites?

2 Not hearing any, let's look at 4b.

3 So 4b is about demonstrating improvement,

4 ultimately this is all about improvement,

5 achieving the goal of high quality efficient

6 healthcare for individuals or populations. So

7 new measures get a pass here but the idea is

8 that -- not a complete pass -- the idea is

9 that there should be a rationale for how the

10 performance results could be used to prove the

11 goal of high quality efficient healthcare for

12 individuals or populations. And if a measure

13 has been in use, then in fact that would be

14 demonstrated.

15 Any thoughts about how this

16 applies to composites?

17 DR. KAPLAN: Are we in 4c or still

18 on 4b?

19 DR. ROMANO: We are on 4b.

20 DR. CHASE: So it is interesting,

21 I don't see a difference in this for

22 composites versus not. But it is -- I only

1 question this now in looking at it in the
2 sense of something like consumer satisfaction,
3 which we might want to measure and people
4 might find valuable and so forth. And even if
5 didn't change, people might still want to look
6 at that.
7 Now again, I am all into all the
8 stuff we do we are always trying to improve so
9 I hope there is change but I would hate to see
10 us stop doing something only because we didn't
11 improve it.
12 And what this sort of implies is
13 an overall that after three or four years if
14 you can't show any improvement in a measure
15 then the measure goes away. Yay! We don't
16 have to worry about that anymore. It didn't
17 do any good.
18 DR. ROMANO: I mean at some point
19 you would say that if you haven't caused any
20 change that it is probably because you can't
21 change that thing, even though you would like
22 to be able to change it. You wish you could

1 change it. But gosh, people have tried for 20
2 years, they haven't been able to change it.
3 There is probably a reason for that. But I
4 agree that three years is too short a time
5 horizon for something that is salient to
6 consumers and patients.
7 DR. GOLDSTEIN: We actually for
8 patient experience measures I think from the
9 hospital side and health plan side, we have
10 been seeing things big improvements.
11 DR. ROMANO: But there are
12 certainly some outcome measures where we have
13 not been able to seen an improvement and I
14 think there is a reasonable argument to be
15 made there that maybe those outcomes are
16 actually much harder to improve than we think.
17 Maybe we don't really know the mechanisms for
18 how to improve them.
19 DR. GOLDSTEIN: I mean we are
20 seeing for the Medicare program on the health
21 plan side, we saw some measures that hadn't
22 changed for years and years and years but once

1 you put the money all of a sudden they are
2 increasing a lot and there is more emphasis on
3 quality improvement. So maybe things they can
4 move if they have the rate incentives.
5 DR. ROMANO: So you shouldn't give
6 up until you have tried a wider range of
7 incentives.
8 Okay, so I think we are agreed 4a
9 and 4b are generally consistent for composites
10 but it really, I do want to emphasize for 4b
11 that it links back to the conceptual
12 framework, the measurement construct. So the
13 rationale that is described here has to be a
14 rationale that links back to that construct.
15 Okay, 4c is about unintended
16 negative consequences. So this criterion
17 emerged from a lot of discussion. I happen to
18 be on this committee but it emerged from a lot
19 of discussion about unintended consequences of
20 performance measurement in practice. And
21 consequences that may not manifest within a
22 single performance measure but maybe if you

1 had another measure you would see that
2 something else is deteriorating, that people
3 are gaming the system, whatever.
4 So this is now embedded from the
5 evaluative framework under usability and use.
6 Thoughts about how this applies to composites?
7 DR. BRATZLER: This is Dale. So I
8 think it definitely does apply to composites.
9 And one of the concerns that we had is we
10 started to working with composites such as the
11 all or none measures but when you had a group
12 of individual performance measures that
13 perhaps had substantial variation and
14 opportunity for improvement but as they
15 improved, when you look at composite weights
16 performance it made the opportunity to look
17 much greater with the composite measure. But
18 then the only way you could get very, very
19 high levels of performance on the composite
20 measure was to achieve near 100 percent target
21 on the individual measures and I think that is
22 problematic, particularly in the

1 accountability since there are not many
2 performance measures that have 100 percent on
3 the target, unless you have perfect
4 specifications that will either be no
5 exception to the performance measure. So by
6 our experience with all-or-none composites was
7 that it tended to drive you towards trying to
8 achieve 100 performance on every single
9 component of the composite, which could lead
10 to unintended consequences.
11 DR. BURSTIN: Especially among
12 measures that are otherwise at very high
13 levels of performance. I don't think it is
14 much of an issue when you are not at those
15 high levels of performance.
16 DR. BRATZLER: That's true. And
17 you know Helen, the one thing that we have
18 seen in virtually every measurement we have
19 pulled out in some accountability format has
20 fairly rapid improvement in rates on the
21 measures, you know versus the individual
22 measures but they tend to improve fairly

1 quickly.

2 DR. KAPLAN: I got stuck on the

3 word evidence because evidence of unintended

4 consequences is a pretty strange concept,

5 especially if you are going to get it by the

6 journal editors who may want to love to

7 publish bad things about quality assessment

8 but evidence of negative consequences is --

9 and it may uniquely apply to composite

10 measures because you are not sure what the

11 collective of those things is going to do to

12 you, especially in things like the all-or-none

13 situation.

14 DR. ROMANO: Well so let's talk

15 about that because again I happened to be part

16 of that discussion. So I think there was

17 concern that there is a lot of hand-waving

18 about unintended consequences, where people

19 say oh, terrible things could happen. This

20 could happen, doctors could discriminate.

21 They could send all the patients to Canada or

22 Mexico. And you know at the end of the day,

1 it is all hand-waving because it is very hard
2 to demonstrate that in fact doctors and
3 hospitals stop being professionals and start
4 behaving like three-year-olds.
5 But so that was the goal here was
6 to say that there actually had to be
7 affirmative evidence of unintended negative
8 consequences. But maybe the wording is not
9 right. Is it different for composites than it
10 is for individual measures?
11 DR. KAPLAN: I'm just concerned
12 that there may not be the caliber of evidence
13 you wanted, evidence counting, capital
14 evidence as opposed to bellyaching.
15 But if there is evidence of actual
16 documented, published evidence that passes
17 peer review and all that scrutiny, different
18 from other -- I'm getting stuck because the
19 composite measures won't immediately be able
20 to tell you that.
21 Further, unless you disaggregate
22 you won't know if it was the fault of one of

1 the individual components of the composite
2 measure or the fault of the collective taken
3 as a group. I am listening to a lot of
4 complaints about I won't even -- all cause
5 admission.
6 But you know, there is a lot of
7 complaining about what is going to happen, oh
8 hand wringing and everything else with yet
9 when we meet the evidentiary criteria here.
10 So for a composite measure I am a
11 little bit more concerned that the evidence is
12 never going to be there to the extent that you
13 want it to be there. Because again it will
14 depend on who you studied, whether that was
15 just a squirrely group or whether it was
16 generalizable to a bigger population, et
17 cetera.
18 DR. SHAHIAN: Yes, I don't think
19 there is any difference between individual and
20 composite measures with regard to this
21 particular concern. I must say, though, it is
22 a very subjective assessment because there

1 are, for example, at least eight papers in
2 CABG and PCI literature over a span now of 15
3 years showing evidence of risk aversion
4 associated with public reporting.
5 Most people have assumed that the
6 benefits outweigh that risk aversion but I
7 don't know how you would ever make an
8 assessment of which is more important, the
9 advantages or disadvantages. But I think
10 there is evidence in some fields.
11 DR. BIRKMEYER: And that is
12 probably the only instance in which there is
13 published evidence --
14 DR. SHAHIAN: Yes.
15 DR. BIRKMEYER: -- about the
16 unintended consequences. And even then it
17 doesn't dissuade anybody's view about
18 measurement being the right thing to do. I
19 wouldn't object to scratching the whole thing.
20 DR. BURSTIN: Well these are
21 actually the general criteria that have been
22 approved for NQF for all measures. This isn't

1 specific to composites. We could certainly
2 take a look at that question. But as Patrick
3 pointed out, the real reason for putting
4 evidence there was the concern that people
5 would just put -- anybody could say oh I have
6 real theoretical concerns about this measure
7 going forward. And it is specifically
8 supposed to be balanced to the benefits.
9 There have been published papers,
10 I mean for example the ED antibiotic
11 administration within four hours clearly
12 published demonstrated. But you are right,
13 they are few and far between.
14 DR. SHAHIAN: Premature activation
15 at cath lab for BCI.
16 DR. BURSTIN: Right. So there are
17 some examples. There are not very many. It
18 is not as if it requires published Big E
19 evidence to use your term. But I think there
20 has to be some accumulating evidence out there
21 that there is potential harm to patients and
22 populations because of it.

1 DR. ROMANO: Okay well so relating
2 this to composites though, it becomes trickier
3 because there might be what if one component
4 in the composite has such evidence but then
5 there are nine other components of the
6 composite that don't. So does that mean you
7 should drop the one that does or does that
8 mean that you should assume that the nine
9 others counterbalance the one that does and so
10 it all comes out in the wash.
11 DR. KAPLAN: Yes, that is very
12 well said because that is what I was trying to
13 get at. You don't -- with a composite,
14 different from individual measures, you don't
15 really know what caused the trouble unless you
16 study it in a disaggregated way.
17 So you would have to build on the
18 evidence that comes from the individual
19 measures and make some assumptions about the
20 composite or you would have to study the
21 composite and then internal to the composite
22 disaggregate it and look at the individual

1 what caused trouble.

2 DR. ZASLAVSKY: Does anybody --

3 can I have an example of a problem of this

4 sort that would arise with the composite that

5 would not exist within the component measures?

6 It seems like in general it has to just --

7 Sherrie suggested the composite would tend to

8 soften the impact of any -- let's say the

9 over-incentivizing of any one thing because it

10 is going to be mixing with a bunch of other

11 things.

12 So you would usually expect the

13 composite to be less likely to produce, as

14 anytime you average together a bunch of

15 things, it kind of generalizes and avoids

16 over-incentivizing some narrow piece.

17 So I'm not sure that we need to

18 state this as an issue for composites unless

19 the only kind of thing I could think of is

20 that someone would look at a composite that

21 combines several things and misinterpret it as

22 actually being due to this, when it is really

1 due to that other component of the composite.
2 But that seems like a very weak kind of
3 unintended consequence.
4 DR. DE LONG: I would think the
5 more relevant concern would be that there is
6 demonstration that one of the composites is
7 doing harm. What do you? As was mentioned,
8 do you throw it out and still use the rest of
9 the components or do you go back to the
10 drawing board for the composite?
11 DR. ROMANO: The options here, it
12 seems, are that we could, at one extreme we
13 could say that 4c simply doesn't apply to
14 composites because composites, in general,
15 dilute, as Alan has stated very well, dilute
16 problems, unintended consequences that come
17 from a single component. So that would be
18 extreme to say 4c just doesn't apply to
19 composites.
20 But if we don't go to that
21 extreme, then how do we rewrite or refrain 4c
22 so that it seems applicable to composites?

1 DR. BURSTIN: I guess I am sort of
2 lost. I mean to me it is what it is. I think
3 it still applies. There may be some special
4 circumstances in understanding what is causing
5 it but to me, again if the composite submitted
6 is required to do 4c, this is the general
7 criteria. This is not unique to composites,
8 but there may be issues where perhaps in the
9 guidance the considerations you would say to
10 the committee, if there is evidence of
11 unintended consequences related to composite,
12 the developer should provide information
13 trying to locate the locus of the issue within
14 the composite. Something like that. I don't
15 know that we need to get into more detail than
16 that.
17 DR. ROMANO: Right. So maybe then
18 the way to frame this is because 4a and 4b, as
19 I read it are about the composite as a whole,
20 4c really is going to be about the components
21 of the composite. So maybe the argument in 4c
22 is that if there is evidence of unintended

1 negative consequences for one of the
2 components of the composite, then the
3 developer should explain how that is handled
4 or justify why that component still belongs in
5 the composite. Is that --
6 DR. SHAHIAN: That's good.
7 DR. BURSTIN: Good work.
8 DR. ROMANO: Okay, so 4a and 4b
9 basically are applicable to the composite as
10 a whole; 4c is applied to individual
11 components with simply a rationale statement
12 or an argument the developer has to make. Is
13 that where we are? Okay.
14 And in some cases the argument
15 might be that the weighting is really low. In
16 other cases the argument might be that it is
17 balanced by something else within the
18 composite. In other cases it might be that
19 they dropped the measure, in the case of
20 pneumonia, I think, where thy increased the
21 time limit actually. That is one that they
22 dealt with it.

1 Okay, so is that it for usability
2 in use? All right.
3 So we go on to -- then end is in
4 sight. So feasibility. We are back up here
5 with the list. Are the feasibility criteria
6 changing?
7 DR. BURSTIN: Not yet.
8 DR. ROMANO: Not yet. There may
9 be a process in the future for changing
10 feasibility criteria?
11 DR. BURSTIN: We are actually in
12 the middle of a project right now looking at
13 eMeasure feasibility and how to assess it. So
14 I think it is going to potentially have some
15 spillover into -- at some point we are going
16 to have to re-do feasibility. It is such a
17 new and different world than it was when we
18 wrote it five years ago.
19 DR. ROMANO: I mean to me the key
20 part of it is really the first part. On the
21 left column it is the extent to which the
22 required data are readily available and

1 retrievable without undue burden and can be
2 implemented for performance measurement.
3 Everything under there is just kind of
4 operationalizing that general principle.
5 So let's look at 4a, b, d, and e
6 on the right side and see if anybody has any
7 comments or suggestions related to those
8 criteria as they are applied to composite
9 measures.
10 MS. PAGET: Patrick, I have a
11 comment and this might be more a general NQF
12 comment. But under 4a where we state
13 routinely generated, right now it is not
14 routine that we generate patient-reported data
15 and maybe, Helen, the PRO project is going to
16 inform these criteria ultimately. But it
17 seems to me that again turning back to the
18 vision that these composite measures are going
19 to be used in areas like purchasing and so
20 forth that we are still making it fairly easy.
21 It is existing data sources that you can
22 readily get to. And I just didn't know

1 whether it is an opportunity for us to put in
2 some different language that recognizes that
3 we hope to get further along with patient-
4 reported data.
5 DR. BURSTIN: That is definitely
6 something you will see woven all through the
7 PRO report. I'm just not sure I know where to
8 put it here but I hear what you are saying.
9 DR. ROMANO: But it is a crucial
10 point because this feasibility framework
11 doesn't incorporate patient-reported data at
12 all.
13 I mean I think the original
14 intent, for example, for the clinical measures
15 was that we didn't want -- NQF doesn't want
16 measures that actually force clinicians to do
17 tests that they are not otherwise doing. You
18 know to send patients to x-ray or do lab
19 tests.
20 So they should be things that are
21 routinely generated concurrent with and as a
22 byproduct of care processes because we are not

1 trying to influence the care process by
2 forcing people to measure things that they
3 wouldn't otherwise measure.
4 DR. KAPLAN: How do you get that
5 from the language that is there?
6 DR. ROMANO: Well there could be a
7 footnote, maybe to clarify what is meant by
8 exclusion there is not forcing people to do
9 tests or to spend money that they wouldn't
10 otherwise do.
11 DR. BURSTIN: I mean it is really
12 about the burden of measurement is really what
13 it is saying. Is the juice worth the squeeze.
14 DR. ROMANO: The burden, including
15 the harm of measurement. I mean potentially
16 you could create a situation where you are
17 actually causing harm by having people do
18 things that aren't a routine part of the care.
19 DR. BURSTIN: I've never really
20 thought about it that way, Patrick. I have
21 always thought about it more as just as the
22 burden of measurement.

1 DR. CHASE: I would just say the
2 exception to that may be where the collection
3 of data is actually part of the care process
4 and collection of PHQ-9 for patients with
5 depression is argued to be one of those. I
6 don't know if that is what you are --
7 DR. ROMANO: Well the counter
8 argument for example is a lot of people have
9 used albumin measures in hospitalized patients
10 because it is a strong predictor of various
11 adverse outcomes. But the argument is that
12 testing albumin leads people to do strange
13 things like giving albumin to try to raise the
14 albumin value, which is not therapeutic.
15 DR. BURSTIN: The only thing again
16 is you go back to the report last time around
17 since it was literally one paragraph on
18 feasibility just indicate that since
19 composites are more complex, the data
20 collection methods are going to need to make
21 sure you can pull in all the different
22 components.

1 So the data collection strategy
2 for obtaining all required components needs to
3 be combined in the composite measure to
4 demonstrate it is feasible. So if you are
5 getting data from all different data sources,
6 all that should come into play as you are
7 looking at the feasibility of composite.
8 Other than that, there was nothing distinct
9 and different.
10 DR. ZASLAVSKY: Are there any
11 issues here about feasibility that are
12 emergent with composite measures in
13 particular? All I can think of is whether
14 maybe you would want to be able to get all of
15 the measures at the same time or something
16 like that, whether there would be -- I don't
17 know whether it is even worth mentioning.
18 DR. ROMANO: I mean it would seem
19 that in general there is presumption that in
20 order for the composite to be feasible that
21 all of the individual components are feasible.
22 Right?

1 DR. BURSTIN: Yes.
2 DR. ROMANO: Because the
3 feasibility will be driven by the least
4 feasible component.
5 DR. ZASLAVSKY: What if you have
6 had a composite that required you to link at
7 the patient level things which come from
8 different sources? That is about the only
9 emergent feasibility issue that I can think
10 of.
11 DR. ROMANO: It's a good question.
12 So how would you frame that in this context,
13 that developers should identify any
14 feasibility issues related to the composite
15 above and beyond the individual measures?
16 DR. ZASLAVSKY: I guess if we just
17 repeat the same language for the composite
18 that we have for the individual measures, that
19 that would cover it.
20 DR. SHAHIAN: The same deficiency
21 does apply though to apply -- the same problem
22 does potentially apply to individual measures.

1 We just did a 30-day CABG readmission measure
2 where we linked the STS clinical database with
3 MedPAR. And that of course was done long
4 after the delivery of care. So it is a
5 general problem, it is not just a composite
6 problem.
7 DR. ROMANO: So I'm not hearing
8 any specific suggestions about things to
9 change in 4a, b, d, and e here recognizing
10 that probably some of the ongoing work related
11 to patient-reported outcome measures and
12 related to eMeasures should drive a more
13 general rethinking of this entire category.
14 DR. GOLDSTEIN: I was going to
15 say, and this isn't I think specific for
16 composites but relates to the individuals,
17 something about auditing the data but if they
18 have like a plan how they are going to audit
19 the data or does it need to be audited or does
20 it need to be checked against other measures.
21 For some of our systems, in particular for
22 high stake systems we spend -- that is a huge,

1 huge area that we spend a lot of time focusing
2 is it audited. Is it audited by independent
3 review? And if it is not, are there other
4 sources of information to validate the data,
5 especially if it is used for pay-for-
6 performance, eventually any of these measures
7 that incentives for gaming increase.
8 So we put penalties if they do
9 anything to bias the rates there is a huge
10 penalty in terms of what we publically report.
11 DR. BURSTIN: That is interesting.
12 I don't think of audibility or auditing under
13 feasibility, more so under validity. And
14 actually it has been something that is, you
15 know, it's too bad David has left the room,
16 that is a big part of what the STS measures
17 have brought forward is the percent sample and
18 auditing et cetera.
19 DR. ROMANO: I have been having
20 trouble with 4d here in general terms. It is
21 a hard sentence to parse, to borrow Alan's
22 description earlier. It is just difficult

1 because the data on inaccuracies and errors
2 and unintended consequences are being
3 described under other evaluation criteria.
4 So this is somehow about the
5 ability to do it. It just seems odd in this
6 context.
7 DR. KAPLAN: I'm confused about b,
8 d, and e buy you for the composite that you
9 don't already have for the individual items.
10 I mean they look to me identical except --
11 yes, so why do you need them?
12 DR. BURSTIN: Because the idea
13 would be sometimes you only just have a
14 composite and are they applicable or not. So
15 all this is saying is yes, those are
16 applicable, same wording applies.
17 DR. KAPLAN: Okay so b then needs
18 all the other junk that is in 4b on the other
19 side? Because right now it is written as
20 assertional versus aspirational. Right?
21 Because some of the data like the
22 patient experience data, supposing you were

1 creating a composite that included patient
2 reported data with other kind of data, that is
3 not in the electronic form right now.
4 DR. BURSTIN: You are right. I
5 don't understand why the difference.
6 DR. ROMANO: So we have raised a
7 number of questions about these criteria in
8 general. Any final comments, suggestions
9 regarding the feasibility criteria?
10 Okay, great! So I think we want
11 to have another opportunity for public
12 comment. We, I think, have basically
13 discarded the idea of a taxonomy, per se.
14 DR. BURSTIN: Yes.
15 DR. ROMANO: So we are not going
16 to discuss that.
17 Do we want to talk at all -- in
18 terms of the submission form, we decided sort
19 of not to go through the submission form in
20 detail because that would be a very tedious
21 exercise. It doesn't add anything.
22 But we do want to give NQF staff

1 guidance about how to redesign or tailor the
2 submission form.
3 And I guess what I would like to
4 hear a little bit of discussion about maybe
5 for five minutes is do we -- I think earlier
6 we decided that there isn't a bright line
7 between composites and other types of measures
8 and that we weren't comfortable with having an
9 entirely different process for composites than
10 for other types of measures. In principle
11 many of the measures that NQF has endorsed as
12 individual measures could be viewed as
13 composites and some of the measures that have
14 been endorsed as composites could be viewed as
15 individual measures, depending on your
16 perspective. So what matters a lot more is
17 the measurement concept or the constructural
18 framework.
19 So how does this relate to the
20 form? Are we going to ask people to declare
21 their measure as a composite or not? Are we
22 going to have questions embedded within the

1 forum that says that if you are building your
2 measure on other measures then you must go
3 over and answer this additional set of
4 questions? Any thoughts about how to
5 structure that in general so that the review
6 process is uniform across steering committees?
7 DR. ZASLAVSKY: I guess one thing
8 would be to have an option to indicate which
9 existing measures are incorporated into your
10 measure. So you sort of incorporate by
11 reference the whatever approval has been done.
12 I guess the other side of it is
13 what -- the thing we have been struggling with
14 is when do you kick in these additional
15 criteria? In a sense, anytime you rely on
16 existing measures, then the new criteria for
17 combining things should kick in. The question
18 is, are there situations where you are not
19 relying on any existing approved measures but
20 you would still want to bring in these
21 criteria. That is where we run into this
22 territory where we have a hard time drawing

1 the line between what is the composite measure
2 and what is just a single measure that happens
3 to incorporate a bunch of different elements?
4 So you know I think we have heard
5 the argument there from several people,
6 including myself that a lot of these criteria
7 we have introduced for the composite measures
8 actually should apply to things that are
9 called single measures but that combine a
10 number of different things. So I am not sure
11 how we address this questions of whether to
12 just make this part of anything that isn't
13 really just completely one thing or do we
14 really try to distinguish the subset for which
15 this is applicable?
16 DR. ROMANO: Very well described.
17 Anyone able to answer Alan's question?
18 DR. DUNTON: Well if you don't
19 have an opportunity to declare it as a
20 composite, then it doesn't trigger in some of
21 the other things which may or may not be
22 added, such as a purpose in the conceptual

1 model. And so I'm not sure you can get away
2 forever with not defining what a composite is,
3 although I don't have a solution.
4 DR. KAPLAN: I have a separate
5 issue, which is the issue of harmonization
6 with related measures and then the competing
7 measures things, e2 and e3. Harmonization is
8 kind of the activity that is involved in
9 creating the composite measures. You are
10 pulling things together that theoretically
11 assess some other construct. So you will try
12 --
13 DR. BURSTIN: No, it is different.
14 So what we are referring to there is
15 essentially comparing what you have inside
16 your composite to other measures.
17 DR. KAPLAN: Other parallel
18 composites.
19 DR. BURSTIN: Other similar
20 constructs.
21 DR. KAPLAN: How often is that
22 going to happen?

1 DR. BURSTIN: Not necessarily just
2 constructs, the individual measures happens
3 half the time in our lives.
4 DR. KAPLAN: Well I know it does
5 with individual measures. I am trying to get
6 at so say you have -- forgive me for math
7 again, but you have your four test questions
8 in algebra. Now somebody else has four other
9 questions that they assert measure algebra.
10 They are very different questions. They both
11 measure algebra. So you are asserting that
12 that other test that has these components is
13 different from my measure in the following
14 ways, blah, blah, blah, blah, blah? Or are
15 you suggesting that now I make an eight-item
16 version of my algebra measure? I am confused
17 with respect to the composite issue. I am a
18 little confused about how this plays out.
19 DR. ROMANO: I think it ties with
20 the broader context and the concern about
21 measurement burden.
22 So just to cite one example from

1 AHRQ's composite. So there is a patient
2 safety composite that includes a measure of
3 central venous catheter associated infections.
4 It is based on administrative data. At the
5 time that was chosen because it was a feasible
6 measure to include in that composite. But
7 there is a practical problem which is now we
8 have another measure which is in Hospital
9 Compare which is based on National Healthcare
10 Safety Network reporting, using specific
11 definitions that come from the CDC. So that
12 is not harmonized.
13 So we have a measure of CLABSI
14 within the PSI composite that is not
15 harmonized with a different measure of CLABSI
16 that is also publicly reported at a national
17 level that is defined by CDC.
18 So one solution to that approach,
19 for example, would be for AHRQ to reconstruct
20 its composite to actually include the CDC
21 measure instead of the measure based on
22 administrative data.

1 Another approach would be to
2 justify why they can't be harmonized based on
3 some superiority of the administrative
4 database measure for this particular
5 application. But I think that is what we are
6 getting at. Does that make sense?
7 DR. KAPLAN: Yes, it just has a
8 different flavor when you are talking about a
9 composite versus -- I get it at the individual
10 measures level. You guys are trying to make
11 sure that you are both coming at this from the
12 same direction. You end up agreeing on
13 denominators and all that other stuff.
14 What is a little different is now
15 you have got three measures that are the same
16 and one measure now that looks oddball and you
17 are going to figure out how to grab that in.
18 What is it going to do to the composite which
19 is a little bit different issue when you are
20 talking about harmonization.
21 DR. CHASE: So the only thing I
22 would hope about this is that we don't put a

1 different burden on composite measures just
2 because we can. Because harmonization should
3 affect, I think, all measures as they come
4 through and I think that is the intent. So
5 when other measures come renewed as well, so
6 in both cases it wouldn't just put it on to
7 the composite measure developers to align with
8 what others have already done.
9 DR. ROMANO: I am not sure that
10 this issue has arisen but theoretically it
11 could arise that different developers could
12 come in with different measures of what they
13 claim is the same thing.
14 DR. DE LONG: Diabetes. We have
15 already done it in diabetes.
16 DR. ROMANO: Right. So then --
17 but actually NQF had decided in that case to
18 endorse both, presumably based on some rich
19 discussion and some rationale.
20 DR. BIRKMEYER: But also --
21 DR. BURSTIN: Rich! I think it
22 was rich.

1 DR. BIRKMEYER: But also just
2 given the possibility that sort of NQF views
3 its role as deciding when a measure is
4 rigorous and even if there are two things that
5 are ostensibly measuring the same things with
6 slightly different tradeoffs, there is a
7 marketplace public and private that will sort
8 out which one ultimately gets used.
9 DR. BURSTIN: Although in that
10 case, the individual components were
11 harmonized. So where the measures overlapped
12 the science was harmonized for the level of
13 blood pressure control, LDL, and A1c.
14 DR. ROMANO: Anyway, there is a
15 separate process I think that AHRQ is
16 currently -- that NQF is currently undertaking
17 internally to review its approaches to
18 harmonization. So that is on the back burner
19 for today.
20 DR. BURSTIN: I'm not getting a
21 whole sense of energy left to do the
22 composite.

1 DR. ROMANO: No, I think people
2 are fading.
3 DR. BURSTIN: I think it might be
4 more useful once we have tried to write up the
5 criteria to come back. I do think that, Karen
6 and I talked about this a little bit earlier
7 that I guess Karen has also suggested that in
8 some ways since there is so much uncertainty
9 that likely the best approach would be to not
10 have a whole separate composite submission
11 form. Have this -- just like do if it is an
12 outcome, is there risk adjustment. If it is
13 a composite, you answer this series of
14 questions. And maybe the question is going to
15 be do we allow the developer to self-trigger
16 is it a composite. We can have our guidance
17 what we think they are. But maybe part of
18 this is also an assessment on the part of the
19 committee of well we actually think this is a
20 composite, you need to go back and answer
21 those questions.
22 So we will play with that a bit.

1 DR. ROMANO: And I think Alan's
2 idea is definitely useful of bringing in other
3 measures by reference and where that cannot be
4 done, then the question is does the developer
5 have to submit separate information about
6 individual components that have not been
7 separately endorsed? So would there be a
8 requirement for a separate submission form for
9 individual measures that are not currently
10 endorsed?
11 DR. BURSTIN: I think some of
12 that, again, comes back to the clarity of what
13 we are actually saying has to be submitted for
14 the components.
15 At least I continue to hear that
16 we talked about the importance to measure
17 report, still needing to be there for both the
18 overall and the components and not always for
19 the -- it is a big waste to have the form have
20 sort of pop out boxes if it is -- you know, be
21 able to fill in the additional information
22 required.

1 But some of this will come back
2 down to the developer as well. Do you want to
3 put forward the new components within your
4 composite as stand-alones for endorsement?
5 And if that is the case, then something else
6 would pop up that they would complete. But
7 that may not always be the case.
8 DR. ROMANO: But if you don't,
9 then there should be a way to invoke a simpler
10 process.
11 DR. BURSTIN: Yes.
12 DR. ROMANO: Yes.
13 DR. ZASLAVSKY: So I don't think
14 there are many of the things that are in the
15 overall criteria that aren't in the component
16 criteria but there are a few that are at least
17 softened or modified so you maybe have a
18 modified version of the form.
19 DR. ROMANO: Should we open to
20 public comment?
21 DR. BURSTIN: Yes.
22 DR. ROMANO: Is there anyone else

1 in the room who would like to comment? In the
2 meantime, we can open the telephone lines.
3 OPERATOR: At this time, if you
4 would like to ask a question, please press *,
5 then number 1. And there are no questions.
6 DR. ROMANO: Going, going, gone.
7 DR. BURSTIN: We're gone.
8 DR. ROMANO: So the public comment
9 period is closed for right now. Next steps.
10 MS. MUNTHALI: So in terms of our
11 next steps, the panel will reconvene via
12 conference call in about two weeks actually,
13 November 15th and we will follow up on any
14 issues that we have.
15 In the process, our team is going
16 to start drafting the technical report with
17 your recommendations. You may be seeing some
18 emails for clarification. We have been taking
19 notes. We also have Eric in the back who is
20 our court reporter and so we will be looking
21 through all of that. I am going through the
22 recording as well.

1 Also after we draft a report, we
2 will give you an opportunity to look at the
3 report before we post it on the NQF website
4 for our member and public comment and that is
5 a 30-day period.
6 But because this is very important
7 work that will influence evaluation guidance
8 for composites, we want to have our Consensus
9 Standards Approval Committee review the draft
10 report before we receive comments from our
11 members and public. We want them to start
12 looking at the material, get comfortable with
13 the issues that you have raised. And so we
14 will go to the CSAC on December 10th and we
15 will have a call to adjudicate the comments
16 that we received during the comment period on
17 January third and go back to CSAC with final
18 recommendations, which also considers our
19 member and public comment on January 8th. And
20 we hope to have Board ratification a few weeks
21 after that, hopefully by the end of January.
22 I don't know if you have any

1 questions on our time line. And of course you
2 can contact Karen Johnson, Karen Pace, or
3 myself. We are on SharePoint. I hope you
4 guys are using it. I'm sorry for any issues
5 you have had if you had any issues.
6 And we just wanted to thank Liz
7 and Patrick for leading such a great
8 discussion today and to thank all of you for
9 coming and we look forward to communicating
10 again online and via phone and safe travel
11 back home.
12 DR. ROMANO: Just a question just
13 to clarify. Any changes to the submission form
14 and procedures would follow this entire
15 process?
16 DR. BURSTIN: Yes.
17 DR. ROMANO: Or would they be done
18 concurrently? We would follow the process?
19 MS. MUNTHALI: Yes.
20 DR. ZASLAVSKY: Will you be able
21 to tell us soon what time the next call is at
22 because some of our schedules are filling up.

1 MS. MUNTHALI: Yes, we are sending
2 that to you. I can tell you it will be in the
3 afternoon but I don't know the exact time. It
4 will be a two-hour block. We have been trying
5 to make sure we accommodate time for the --
6 DR. BURSTIN: Three to five.
7 MS. MUNTHALI: -- three to five,
8 right?
9 DR. BURSTIN: Yes, 3:00 to 5:00 on
10 November 15th.
11 MS. MUNTHALI: So we will send that
12 in an email and post it on SharePoint as well.
13 DR. ROMANO: Okay and if there are
14 any other suggestions for NQF or for me and
15 Liz, please let us know. Thanks again.
16 DR. BURSTIN: Thank you for such
17 able facilitation of a tough topic. And thank
18 you all. This was an interesting
19 methodologically challenging day. Thank you
20 for your brain power for the day.
21 (Whereupon, the above-entitled
22 matter went off the record at 4:13 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Composite Measure Evaluation Guidance Project Expert Panel

Before: NQF

Date: 11-02-12

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter