NATIONAL QUALITY FORUM

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EFFICIENCY RESOURCE USE

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STEERING COMMITTEE MEETING

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TUESDAY
JULY 13, 2010

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The Steering Committee convened at 9:00 a.m. in Suite 600 South of the Homer Building, located at 601 13th Street, N.W., Washington, D.C., Doris Lotz and Bruce Steinwald, Co-Chairs, presiding.

PRESENT:
DORIS H. LOTZ, MD, MPH, CO-CHAIR
BRUCE STEINWALD, MBA, CO-CHAIR

PAUL BARNETT, PhD, VA Palo Alto Healthcare System
JACK BOWHAN, Wisconsin Collaborative for Healthcare Quality
JEPTHA CURTIS, MD, FAAC, Yale University School of Medicine
KURTIS ELWARD, MD, MPH, FAAFP, Family Medicine of Albemarle
WILLIAM GOLDEN, MD, MACP, Arkansas Medicaid
LISA M. GRABERT, MPH, American Hospital Association
ETHAN A. HALM, MD, MPH, University of Texas Southwestern Medical Center
ANN HENDRICH, RN, MSN, FAAN, Ascension Health
JACK NEEDLEMAN, PhD, FAAN, UCLA School of Public Health

MARY KAY O'NEILL, MD, MBA, CIGNA Healthcare
DAVID PENSON, MD, MPH, Vanderbilt
University Medical Center
STEVE PHILLIPS, MPA, Johnson & Johnson
Health Care Systems, Inc.
DAVID REDFEARN, PhD, WellPoint
JEFFREY B. RICH, MD, Mid-Atlantic
Cardiothoracic Surgeons, Ltd.
WILLIAM RICH, MD, Northern Virginia
Ophthalmology Associates
TOM ROSENTHAL, MD, UCLA School of Medicine
BARBARA A. RUDOLPH, PhD, MSSW, The Leapfrog
Group
JOSEPH STEPHANSKY, PhD, Michigan Health and
Hospital Association
JAMES N. WEINSTEIN, DO, MS, Dartmouth
Hitchcock Medical Center
DOLORES YANAGIHARA, MPH, Integrated
Healthcare Association

NQF STAFF PRESENT:

HELEN BURSTIN, MD, MPH
JANET CORRIGAN, PhD
MAISHA MIMS, MPH
JENNIFER PODULKA, MPAff (Phase 1)
SALLY TURBYVILLE, MA, MS

ASHLIE WILBON, RN, MPH

ALSO PRESENT:

NIALL BRENNAN, CMS
RITA MUNLEY GALLAGHER, PhD, RN

NOT PRESENT:

THOMAS H. LEE, MD, Partners HealthCare
System, Inc.
RENEE MARKUS-HODIN, JD, Community Catalyst

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

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Adjourn

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

2 9:01 a.m.

3 MS. TURBYVILLE: Okay. Good

4 morning. Welcome for our second day of the

5 Resource Use Steering Committee. I believe

6 the conference line has been opened, so the

7 public now is, if any --

8 OPERATOR: Would you like to start

9 the call, ma'am?

10 MS. TURBYVILLE: I'm sorry?

11 OPERATOR: This is your conference

12 operator.

13 MS. TURBYVILLE: Yes, please, go

14 ahead and start the call.

15 OPERATOR: Shall I start the call?

16 MS. TURBYVILLE: Yes. Thank you.

17 OPERATOR: Okay.

18 MS. TURBYVILLE: I can't really

19 hear him. I don't know if my ears are stuffed

20 up. Okay.

21 OPERATOR: Please, note today's

22 event is being recorded. Please, standby.

1 MS. TURBYVILLE: Okay. So I'll
2 just briefly kick it off and hand it over to
3 the Co-Chairs. We are going to summarize some
4 of the key discussions and decisions from
5 yesterday and make sure we heard all the
6 various inputs correctly.
7 We are going to skip what was
8 originally on the agenda at 9:15 for the
9 Current and Future Environment that would
10 affect resource use measures. When we were
11 debriefing yesterday, we felt like throughout
12 the day a lot of the Steering Committee had
13 mentioned and we had discussed quite a bit of
14 that.
15 We can circle back to that at the
16 end of the day, if necessary, but we did feel
17 that some of the market implications, et
18 cetera, had been discussed.
19 And so we are going to dive then
20 right into walking through the details of the
21 evaluation criteria. And we have produced the
22 handout that has the analytic steps that we

1 discussed yesterday, but they are no longer
2 grouped into three modules.
3 And so that will just be a handout
4 to help remind ourselves what we are thinking
5 about in the evaluation criteria.
6 CO-CHAIR STEINWALD: Is this --
7 MS. TURBYVILLE: No, not yet. We
8 were going to wait until we --
9 CO-CHAIR STEINWALD: Okay.
10 MS. TURBYVILLE: -- got there.
11 CO-CHAIR STEINWALD: Okay.
12 MS. TURBYVILLE: So that's okay.
13 No, it's good. Everyone is, you know,
14 anticipating the work. I like it. That's
15 good.
16 So quickly, I'm going to go over
17 what we presented to all of you during the
18 webinar on June 18th. So I won't spend too
19 much time, but I just want to make sure we are
20 starting on the same page. If I'm going to
21 fast, feel free to stop me and ask questions.
22 And then, as I said, we will go

1 right into the principles and the criteria
2 themselves.
3 So there are conditions for
4 consideration that have to be met even before
5 a measure will be evaluated. And there are
6 four of them. And then there are four main
7 evaluation criteria with a fifth criteria that
8 is meant to be a tie-breaker.
9 So all those who are submitting
10 measures must agree and have a measure steward
11 for the measure who would be responsible for
12 seeing the measure through the submission
13 process and maintaining it as necessary over
14 the course of the three years until it is
15 explicitly brought up for reevaluation.
16 The measures must be intended for
17 both public reporting and quality improvement.
18 And they clearly must complete the measure
19 submission form, so that it can be evaluated
20 appropriately.
21 As you heard yesterday -- yes,
22 please.

1 DR. JEFFREY RICH: My question is
2 is that quality improvement or is it intended
3 for efficiency?
4 MS. TURBYVILLE: Yes, I mean, that
5 would be one of those -- it's a standing
6 language, but I would say it's probably
7 resource use improvement, yes.
8 DR. JEFFREY RICH: All right.
9 MS. TURBYVILLE: In this case or
10 efficiency.
11 DR. JEFFREY RICH: The resource
12 use --
13 COURT REPORTER: Can you turn your
14 mike on?
15 DR. JEFFREY RICH: Oh, sorry. My
16 question was is it really quality improvement
17 that we are using these measures for? I
18 think it is looking at eventually at
19 efficiency. And so maybe the outcome of this
20 whole effort is to look at measures of
21 efficiency, but however you want to word it.
22 MS. TURBYVILLE: Yes.

1 DR. JEFFREY RICH: I don't think
2 it is quality improvement.
3 MS. TURBYVILLE: Yes, yes. Okay.
4 That's fair. Then there are four main
5 criteria that need to be met and this is where
6 the Steering Committee and the Technical
7 Advisory Panels come in. They must be
8 considered important to measure.
9 If they are not important to
10 measure, then they are not evaluated on the
11 remaining criteria. We can stop and send it
12 back to the measure submitter and say that
13 they haven't met this criteria. They may want
14 to try and submit more information, depending
15 on the reason.
16 They must be scientifically
17 acceptable, which would lead it to be able to
18 give valid conclusions and wouldn't be, again,
19 about quality in this case, but about resource
20 use.
21 The measure must be usable and
22 related to some kind of decision making

1 process. And they must be feasible. So they
2 must be something that the user can actually
3 produce and implement.
4 Within each of those four
5 criteria, there are sub-criteria and that's
6 where some of the additional components may be
7 applied by all of you, expansion of language,
8 et cetera.
9 One thing to note it is often not
10 an all or nothing as the Steering Committee
11 reviews the measure. Okay.
12 In the best-in-class criteria,
13 that's really when you have two measures that
14 are considered to be measuring the same thing
15 and it is a way in which the Steering
16 Committee can decide which one to push forward
17 for endorsement.
18 We are trying to avoid, and I
19 think there are, some from back longer ago
20 where we have a lot of quality measures that
21 are very similar. It causes confusion for
22 users. So there is a real push for Steering

1 Committees now to really select the one that
2 is doing a better job of capturing what is of
3 interest.
4 DR. REDFEARN: Isn't there a set
5 of targets that all of the bidders are going
6 to have to aim for? So isn't it inevitably a
7 part of this process that they are all going
8 to be targeting the same things, so there is
9 going to be overlap?
10 MS. TURBYVILLE: So an example --
11 well, you mean by resource use?
12 DR. REDFEARN: I mean, you have
13 categories of things that are going out that
14 you want them to develop measures for, right?
15 MS. TURBYVILLE: Yes.
16 DR. REDFEARN: So aren't they
17 inevitably going to all be doing the same
18 thing?
19 MS. TURBYVILLE: Yes, that's --
20 DR. REDFEARN: Or am I
21 misunderstanding?
22 MS. TURBYVILLE: -- I mean, right.

1 So for example, you could -- in the quality
2 world there may be similar measures of blood
3 pressure, but perhaps it's for a different
4 population.
5 So for diabetes you might have a
6 different clinical threshold of interest. It
7 is possible that some of them will be very
8 similar in the population for which they are
9 measuring and then how they are measuring it.
10 And at that time, there might be -- there
11 would be a need to decide if one is doing a
12 better job of capturing the population and
13 measuring something that is more important.
14 If they are different populations
15 or different episodes in similar areas, that
16 may not be considered the same measure.
17 DR. JEFFREY RICH: Would we then,
18 if you have one then, with a measure of
19 diabetes in a commercial population and one,
20 a measure, in Medicare populations or
21 something like that, would you have two
22 measures, if you think they are both quality

1 measures that you want to keep? Would you end
2 up with two?
3 DR. BURSTIN: Potentially, yes,
4 but we would require that they be harmonized
5 as much as possible.
6 MS. TURBYVILLE: Yes.
7 DR. BURSTIN: I mean, ideally, we
8 don't prefer that. We would like it to be
9 one, but often times the data systems don't
10 allow it to be one. And certainly our
11 preference would be one.
12 I mean, I think the other thing I
13 think we are going to see is that we will
14 likely have similar looking measures submitted
15 for different levels of analysis.
16 MS. TURBYVILLE: Yes.
17 DR. BURSTIN: So I suspect, for
18 example, we know of some health plan level,
19 you know, resource use measures that will
20 likely be submitted as well as some clinician
21 or group level measures that will be
22 submitted. So I think that will be the issue

1 for us.

2 MS. TURBYVILLE: Yes.

3 DR. GOLDEN: Well, that's an

4 interesting question. In a call for measures,

5 I have -- maybe I have missed it over the

6 years, but are we going to make statements as

7 to what levels of the system to have these

8 measures being submitted? Because boy, that

9 just geometrically expands your buckets. And

10 it may be even easier to do regional or system

11 level measures than it is to do individual

12 position level, clinician or unit level.

13 But boy, what kind of a portfolio

14 do you want?

15 CO-CHAIR STEINWALD: Did you just,

16 I want to make sure I understood what you

17 said, you said assistance to the --

18 DR. GOLDEN: No, a system. System

19 levels.

20 CO-CHAIR STEINWALD: System

21 levels.

22 DR. GOLDEN: So when we call for

1 the measures, are we looking at system level
2 measures, plan level measures, clinician level
3 measures, all of them? If so, I think we need
4 to make explicit statements to say boy, that
5 certainly complicates even this paper if you
6 start to look at it in those kind of
7 frameworks.
8 MS. TURBYVILLE: And I think
9 that's, you know, a very important question.
10 I think we were thinking broadly in different
11 systems. Certainly, we want physician
12 measurements. We know the funder is
13 interested in that, but that there are other
14 resource use measures out there that are
15 looking at different units of analyses.
16 DR. GOLDEN: I would recommend
17 that we be a little more focused than that.
18 MS. TURBYVILLE: Yes.
19 DR. GOLDEN: Either you do want
20 them or you don't want them. I don't think we
21 should just kind of be vague.
22 DR. BURSTIN: We're usually not

1 vague. We are usually quite explicit on the
2 call for measures of what level of analysis we
3 are seeking. And to date, I think out
4 expectation was certainly at the clinician or
5 group level and I think there is a great deal
6 of interest as well at the health plan level.
7 I don't know that there is other
8 levels of analysis. I don't think we are
9 talking about hospital or anything like that.
10 DR. BURSTIN: So again, this is
11 something I think will work with you and also
12 with HHS on to figure out what the right level
13 the hit is, but I would assume at least those
14 two.
15 DR. GOLDEN: Well, because I think
16 it's an important thing to clarify, because it
17 could change the content of the paper.
18 CO-CHAIR STEINWALD: If you are
19 taking questions now, it's Steve and then
20 Paul.
21 MR. PHILLIPS: Yes, well, just I
22 guess a comment on referencing back to an

1 earlier panel that I was on. This came up in
2 the context of, you know, I think we are
3 looking at expecting individual measures and
4 got submissions that were more like the
5 examples in the addendum to the paper here
6 where you had -- you know, there is different
7 models out there that cover a range of
8 conditions and there is a lot of overlap.
9 And so I think this question of
10 harmonizing in terms of whether we are going
11 to pick the best of, you know, groupers that
12 say that -- you know, cover a range of
13 conditions or, you know, try to sort that out
14 in terms of digging down beyond just the
15 system itself or, you know, are we going to,
16 in this case, endorse more than one, even
17 though there may be substantial overlap for
18 all things. I think we are going to have to
19 work through.
20 MS. TURBYVILLE: Yes, that's --
21 CO-CHAIR STEINWALD: Let me just
22 add here, refer to the agenda, after our last

1 substance segment is done, guidance for
2 developers, it seems to me that this is where
3 we address what kind of information are you
4 going to give to the developers about the
5 kinds of measures that we are seeking.
6 You know, personally, I hope that
7 we can be as broad as we can be. But on the--
8 do you want to get through with your overview?
9 MS. TURBYVILLE: I do, because --
10 CO-CHAIR STEINWALD: And then get
11 into it?
12 MS. TURBYVILLE: -- this is all
13 very important input and I want to make sure
14 that we are looking at what we have now and
15 keeping the group moving forward as
16 efficiently as possible.
17 CO-CHAIR STEINWALD: Right. So we
18 will --
19 MS. TURBYVILLE: And give Paul a
20 final comment though.
21 CO-CHAIR STEINWALD: Yes, let's,
22 yes.

1 DR. BARNETT: Well, it's not a
2 comment. It's a question about how this works
3 that the choice of best-in-class. So can you
4 give us an example of how where you have had
5 competing measures for quality, what sort of
6 evidence you would use to choose? Because I'm
7 having trouble figuring out how we do it.
8 If, you know, we have two packets
9 from two different groups, how are we going to
10 possibly compare them?
11 DR. BURSTIN: Yes, so I'll start.
12 This is still a work in progress. As Barb
13 knows who sits on our CSAC, it's a big point
14 of discussion over the next couple of days.
15 To date, what we have done is now
16 that our criterions have criteria are quite
17 objective with clear cut ratings, what we have
18 done to date is we asked the Steering
19 Committee and the TAPs to rate the --
20 particularly the Steering Committee to rate
21 each of the criteria and sub-criteria for each
22 measure.

1 First, we make the assessment
2 that, in fact, both measures would be likely
3 to be potentially endorsed, given the fact
4 that they both meet the criteria. We then
5 look at them side by side and literally, as
6 you will see when you get to the point of
7 doing the actual review of the measures, you
8 will be asked to rate every single sub-
9 criterion from completely met, somewhat met,
10 partially met, not met at all.
11 So you will be able to see them
12 lined up side-by-side. This is when the
13 multi-stakeholder issue really comes to play,
14 because you will be able to see for, example,
15 there may be some measures or scientific
16 acceptability as higher on one and yet
17 feasibility and usability are higher on
18 another.
19 So this is where I think, other
20 than importance, which is a must pass
21 absolute. I think you start to see some of
22 the give between those two and the Committee

1 tries to make that determination.

2 What we have started to do

3 recently, until we start to get some better

4 insight from the CSAC and the Board in the

5 short-term, is in a project we are doing

6 currently, we are just putting out both

7 measures for comment, at least, saying here is

8 the rating, here is the sub-criteria ratings,

9 the Committee really felt both of these could

10 potentially go forward, give us your input.

11 We try to make it work, so that if

12 they are truly different enough, different

13 data source, different population, potentially

14 we can live with them in the short term.

15 We have also got another Steering

16 Committee currently doing a whole effort on

17 operational guidance for us on harmonization.

18 How much latitude do we have to go back to

19 developers and say, to really make these two

20 to be able to coexist in the portfolio, you

21 have got to agree that the age cutoff, for

22 example, of COPD begins at age 40 or things

1 like that. But it is definitely a work in
2 progress.
3 I also don't think there is that
4 many measures in this particular area. So I
5 think you're going to have, maybe I'm wrong,
6 less here than you do with, for example, a
7 call for clinical process measures in diabetes
8 or something where, you know, we could get
9 hundreds of various clinical kind of process
10 measures submitted. But time will tell.
11 CO-CHAIR STEINWALD: Go ahead.
12 MS. TURBYVILLE: So the approach
13 that we are going to use as we move through
14 the evaluation criteria with all of you right
15 now is that it must build upon the current NQF
16 Measure Evaluation Criteria.
17 And then as we look at the sub-
18 criteria, you will see that based on the
19 webinar and then other comments that we got
20 after the webinar, we have expanded some of
21 the language, added some sub-criteria, but our
22 goal here today is really to be able to walk

1 away with a good idea for NQF staff of what
2 other changes we need to make so we can
3 continue to move this forward.
4 Because as you all noted
5 yesterday, this document needs to be ready for
6 the measure developers when they are
7 submitting the measures, so they understand
8 clearly, and we're being transparent, what
9 they are going to be evaluated on.
10 So I'll hand it back to all of
11 you. The way we had it setup here was to
12 review the evaluation principles first and
13 then the criteria, but you are more than
14 welcome to switch that if you think the
15 reverse is better.
16 CO-CHAIR STEINWALD: Principles
17 first.
18 CO-CHAIR LOTZ: Are you all right
19 with that?
20 CO-CHAIR STEINWALD: Yes,
21 principles first.
22 CO-CHAIR LOTZ: Yes, let's go

1 ahead and do the principles first, because I'm
2 probably going to send us on a pathway of
3 several hours of conversation. You have seen
4 them before. I won't actually speak the words
5 you all know I want to speak.
6 And I'm hoping that with just
7 perhaps a few additions from yesterday's
8 conversation, that we are pretty much on
9 target with this.
10 Now, I was asking yesterday, this
11 document becomes a useful document, I think,
12 to inform the White Paper, potentially to
13 inform any written work after that. It is
14 something that would be included in the call
15 to measures.
16 But they are sort of the higher
17 level thinking that we have before we move the
18 conversation from there into some real
19 concrete thinking. So when we get to the
20 actual evaluation measures, we really need the
21 group to come out of the theoretical and to be
22 as specific and actionable as we can when we

1 get to those measures.

2 So this is your, not last time,

3 but, next time to kind of think in very broad

4 terms about what this project ought to be

5 like. And this was in the packet yesterday,

6 right?

7 MR. STEWART: Yes. It's on page

8 29 of 30 in your white paper that's in the

9 packet and they are also listed here, so

10 whichever works best for everyone here.

11 CO-CHAIR LOTZ: I thought they

12 were. I thought we were given a single sheet

13 of the principles?

14 CO-CHAIR STEINWALD: There is,

15 okay.

16 CO-CHAIR LOTZ: We'll just go

17 through them one by one.

18 CO-CHAIR STEINWALD: Yes, why

19 don't you steer us.

20 CO-CHAIR LOTZ: Bruce is coming

21 down with an upper respiratory infection, so--

22 CO-CHAIR STEINWALD: No, no, I'm--

1 well, I'll hang in there. If I squeak at
2 anybody --
3 CO-CHAIR LOTZ: We are actually
4 including the prodromal period, which goes
5 back. We will figure out how many days. We
6 will discuss that later on.
7 How does the group want to do
8 this? You know, again, it's a document you
9 are familiar with. Do you want to go through
10 it bullet-by-bullet? Quickly, let's go
11 through it bullet-by-bullet then. And
12 unfortunately, I don't have a laptop in front
13 of me, so I can't see what's behind me.
14 MS. TURBYVILLE: Do you want to
15 use this?
16 CO-CHAIR LOTZ: No. Because you
17 want to edit in real-time. So why don't you
18 just hang on to it and I'll turn around
19 periodically.
20 MS. TURBYVILLE: Okay.
21 CO-CHAIR LOTZ: So the first one,
22 resource use measures are measures of input.

1 They are not measures of quality. So this is
2 something that again reflects our conversation
3 already. It's certainly related to quality
4 itself.
5 Resource use measures are an
6 important building block to measures of
7 efficiency of care, future measurement efforts
8 should integrate explicitly corporate quality
9 or appropriateness performance.
10 Additional comments? Barbara?
11 DR. RUDOLPH: Well, not to nitpick
12 through it.
13 CO-CHAIR LOTZ: No, this is
14 actually your time to nitpick.
15 CO-CHAIR STEINWALD: Yes.
16 CO-CHAIR LOTZ: We are okay with
17 some wordsmithing today, because we want to
18 get as close to a final product as we can.
19 Knowing that there are a few people out of the
20 room, knowing that people want to marinate
21 their ideas, you will see it again before it
22 goes full and final, but go ahead and do some

1 moderate wordsmithing now.
2 DR. RUDOLPH: Okay. Mine is
3 under --
4 COURT REPORTER: Can you turn your
5 mike on?
6 DR. RUDOLPH: My comment is about
7 this first one when it says they are not
8 measures of quality.
9 I guess I would be happy with
10 something that they are not direct measures of
11 quality. I think often times they are proxies
12 for quality or indirect measures of quality.
13 Certainly, if you are a patient and you are
14 subjected to, you know, over the course of a
15 year, seven MRIs that you don't need, it is a
16 question of or becomes a question of quality.
17 It's a question of resource use.
18 But it's also a question of quality. So it's
19 a suggestion.
20 CO-CHAIR LOTZ: Okay. Paul?
21 DR. BARNETT: Yes. I would change
22 this one that says future measurement efforts

1 should, to be the best measurement efforts
2 should integrate -- per best measurement
3 efforts integrate explicitly and incorporate
4 quality or appropriate performance.
5 So if we say it's in the future,
6 then they just blow it off, because that means
7 this time we don't have to do it. Whereas, I
8 would rather have them say okay, it's
9 optional, but if you do it, you're going to
10 rush to the top of the heap.
11 CO-CHAIR LOTZ: Mary Kay?
12 DR. O'NEILL: I'm still kind of
13 circling back to this concept, I think, that
14 the first sentence has "which resource use
15 measures are measures of inputs." But then a
16 lot of the discussion and verbiage throughout
17 the rest of it really is dealing with quality
18 or efficiency, because you are comparing
19 resource inputs and different cases and
20 looking for reasons of variability and all of
21 those imply a judgment of either quality or
22 efficiency.

1 I mean, if what we are calling for
2 our measures that show that we can accurately
3 and robustly count inputs and that's the only
4 building block we are doing, that is quite
5 different than this whole scope of
6 conversation that we're having.
7 And maybe, you know, I just think
8 if we are explicitly looking at counting
9 inputs for the purpose of comparing systems
10 and efficiencies and we are not just trying to
11 figure out robustly how to count inputs in an
12 accounting way of thinking, that we need to be
13 explicit about that from the get-go.
14 And I am just encountering
15 confused thinking, at least in my own mind,
16 about what we are doing.
17 CO-CHAIR LOTZ: Jim?
18 MR. WEINSTEIN: Yesterday, we
19 talked a little bit about the question of what
20 poor performance was in that third sentence.
21 And it might be ultimately understand --
22 unexplained variation in performance.

1 I mean, who is going to judge poor
2 and by what criteria? But I think unexplained
3 variation and performance allows some levity
4 there.
5 CO-CHAIR LOTZ: Okay. Well, jump
6 into the conversation. I don't think you have
7 to be passive in it.
8 Mary Kay, we are -- I was just
9 asking Sally what she wants to get from this
10 group. And again, we spoke a little bit
11 yesterday, but we need to modify expectations
12 as well, so that we can appropriately get to
13 the endpoints we have to at the end of the
14 day.
15 And is there language that you can
16 think of? I'm reflecting back on what you are
17 saying and the second sentence isn't doing it
18 for you. Where do we need to tease it? There
19 are other people nodding, so this is not
20 putting the burden on Mary Kay.
21 DR. O'NEILL: No.
22 CO-CHAIR LOTZ: So if you can help

1 with some choice words.
2 DR. O'NEILL: I'm not saying that
3 we have to limit ourselves to counting inputs.
4 But at the beginning of the day yesterday,
5 that was my understanding of the discussion is
6 that we are doing a building block. And the
7 building block is counting resource
8 utilization.
9 Now, doing -- the science of
10 counting resource utilization, I probably am
11 not completely familiar with how accurate and
12 efficiently we can actually do that
13 performance. And that may be enough work for
14 a scope of a project by itself.
15 But all of the other talk here
16 yesterday and today and in the papers has to
17 do with counting resources in ways that rank
18 physician performance, that look at
19 variability and all of those things imply that
20 we are making some kind of measure of outcome.
21 And if we are doing resource
22 utilization count in relationship to some

1 measure of outcome, I think that's completely
2 fine. I just think that needs to be very
3 explicit at the top.
4 CO-CHAIR LOTZ: So brought out a
5 little bit?
6 DR. O'NEILL: I'm not voting for
7 one or another, but I'm voting for
8 explicitness of purpose of this whole thing
9 from the get-go, from the start. And for me,
10 I'm confused in the different things that have
11 been said. So if I'm confused, my worry is
12 some other reader of the white paper may also
13 end up being somewhat confused.
14 MS. TURBYVILLE: So it sounds like
15 it was the word, in particular, "inputs" that,
16 you know, it's not just an input because we
17 are actually coming out with an outcome, which
18 is a count and sometimes monetized measure of
19 the resources for whichever population?
20 DR. O'NEILL: No. Inputs are
21 fine. It's just that we need an explicit
22 introductory statement that we are counting

1 resource inputs in relationship to --
2 CO-CHAIR LOTZ: Improving health
3 outcomes.
4 DR. O'NEILL: -- outcomes as
5 opposed to saying inputs are a building block
6 and that's what we are counting. You know, we
7 need to say what the purpose of this overall
8 thing is very explicitly. And if we are
9 counting -- and the purpose of this is to
10 figure out how to robustly count inputs in
11 order to relatively rank or to evaluate
12 effectiveness or to look at the return on
13 investment for quality outcome or what ever
14 thing we want to say.
15 CO-CHAIR LOTZ: Yes.
16 DR. O'NEILL: I mean, I'm not
17 glomming onto a word. This is much more
18 conceptual.
19 CO-CHAIR LOTZ: It seems like an
20 incomplete thought to you.
21 DR. O'NEILL: Yes.
22 CO-CHAIR LOTZ: I've got Paul,

1 Jim, Tom. Well, Tom, you kind of kept raising
2 your hand there, so I'm not sure what to do
3 with you, and Jack. Oh, and Bill, sorry. All
4 right. So, Paul?
5 DR. BARNETT: Yes. So I guess
6 where I'm stuck and sort of following-up on
7 what Mary Kay is saying is why are we calling
8 it resource use? And why aren't we calling it
9 efficiency? And if -- because that's what we
10 have been talking about is quantity of
11 resources per population served.
12 And it's about efficiency and I'm
13 not sure its recourse use seems a little bit
14 of an euphemism or a backing away from what it
15 is that we are talking about.
16 CO-CHAIR LOTZ: Yes.
17 DR. BARNETT: But they are
18 efficiency measures. And so I would wordsmith
19 that to say, you know, efficiency measures
20 characterize the quantity of resources per, I
21 don't know, unit of health output or per size,
22 per population served, something like that.

1 Because I think that's what we are
2 asking for, isn't it, in the measures?
3 CO-CHAIR STEINWALD: No, no.
4 DR. NEEDLEMAN: No.
5 DR. BARNETT: We're not?
6 CO-CHAIR LOTZ: Eventually, it's
7 what we are asking for.
8 CO-CHAIR STEINWALD: Yes.
9 CO-CHAIR LOTZ: But we are trying
10 to limit our task to just measuring the
11 resource use. But let's continue on, because
12 there are plenty of folks who would like to
13 speak. Jim?
14 MR. WEINSTEIN: Well, just on the
15 poor performance. The reference, I didn't
16 know what the reference was listed there and
17 if there is one. There are articles that talk
18 about resource utilization and performance in
19 the actual document on page 30.
20 CO-CHAIR LOTZ: Okay.
21 MR. WEINSTEIN: It lists the
22 reference 20 and it doesn't really reference

1 anything. Is that a footnote?
2 CO-CHAIR LOTZ: Yes.
3 MS. TURBYVILLE: Yes, and that's
4 correct, because the hope was to revisit it
5 with all of you and make sure --
6 MR. WEINSTEIN: But there are
7 references around resource utilization and
8 performance.
9 MS. TURBYVILLE: Right. I think
10 it was more around -- during the webinar we
11 talked about what would poor performance for
12 resource use, how would that be defined by the
13 Committee? And there was some sense that high
14 variation would be enough and we just wanted
15 to make sure we circled back and captured all
16 of that information, so that we will remove
17 that reference or footnote. Jack?
18 DR. NEEDLEMAN: Okay.
19 CO-CHAIR STEINWALD: Microphone.
20 DR. NEEDLEMAN: I've been
21 listening to the discussion and trying to
22 figure out what I would do with this first

1 paragraph. And at the risk of offering very
2 specific wordsmithing, which one should never
3 write by Committee.
4 I would get rid of everything in
5 that first sentence starting with the open
6 paren, because I don't think it is adding
7 anything.
8 If we feel we need to make the
9 statement, "they are not explicitly measures
10 of quality," I would at least get rid of the
11 parenthetical remark, because we have talked
12 about many different ways of measuring the
13 inputs over the last few days beyond either
14 RBUs or costs. And this sentence does not
15 capture the richness of that conversation.
16 Paul's press for efficiency, I
17 think, does -- well, I was one of the folks
18 saying no, no. It does capture the fact that
19 these measures are being -- the resource use
20 measures are being used in coordination right
21 now with measures of outcome or quality.
22 And that could be noted in here.

1 What we don't have are true measures of
2 efficiency which fully integrate the resource
3 use and the outcomes or quality measures. And
4 that's what is missing. That is the future
5 direction. In order to get there, we do need
6 to get the resource stuff right.
7 But I think we could at least
8 acknowledge the way in which these measures
9 are being used, which is they are often used
10 in conjunction with or concurrently with
11 measures of outcomes for quality.
12 Tom explicitly said that
13 yesterday. He said I got my report. You
14 know, I've got my dashboard and I've got my
15 resource use measures and I've got my quality
16 measures. And he is trying to do that kind of
17 integration on the fly intuitively and
18 inductively because we don't have explicit
19 ways to do it yet.
20 We are not there yet. But we
21 should at least acknowledge that the way Tom
22 is doing it is the current state of the art.

1 To do it right, you have to have good or
2 better resource measures than we now have.
3 CO-CHAIR LOTZ: David?
4 DR. PENSON: I'm also wrestling
5 with the concept here. And I have to say I
6 don't think we are looking at efficiency
7 measures here. And I think that, at least in
8 my opinion, an efficiency, if we define
9 efficiency and let's define it for a minute,
10 it's getting the same outcome with less.
11 Okay. So Barbara's comment about
12 some patients have seven MRIs, if the outcome
13 is the same, absolutely, you should have three
14 versus seven. But if the outcome is better
15 with the seven, that's not necessarily less
16 efficient or worse care.
17 What I would say here is we have
18 to make a religious decision, which is do we
19 want to even cross over that bridge and say we
20 want to do efficiency which means we have to
21 have quality in the numerator.
22 I personally would say no, but

1 that's just me. But then if we say okay,
2 we're not going to do that, then we are just
3 doing resource use, with some -- the real
4 thing we are doing here and this doesn't
5 necessarily help, but maybe it can get us to
6 the wordsmithing, isn't it how many of
7 whatever are we using, whether you are
8 counting as dollars, RBUs, tests?
9 What we are really talking about
10 is how we are putting our bucket together.
11 Does that make sense to people? So in other
12 words, are the episode group that we see from
13 Prometheus or other groups, are they valid?
14 Do they make sense on the per capital level?
15 So is there some way to say that,
16 if that's the road we are going down? It's
17 not the inputs of the use, it's how we group
18 it together. It's the bucket that I think we
19 are getting at if that follows with people.
20 CO-CHAIR LOTZ: Bill? Bill
21 Golden, pardon me.
22 DR. GOLDEN: I think I'm still

1 Bill, but, okay.
2 CO-CHAIR LOTZ: Yes, you're still
3 Bill. I just got the --
4 DR. GOLDEN: Yes.
5 CO-CHAIR LOTZ: -- wrong Bill.
6 DR. GOLDEN: I want to follow-up
7 on what Mary was saying. I could tell you all
8 are getting a little uncomfortable with my
9 comments earlier about levels and so forth,
10 but I think that we are missing an
11 opportunity, because we are not being
12 explicit.
13 And I was just kind of scanning
14 through the paper and remember yesterday we
15 talked about the left side and the right side
16 of the continuum. And if you look at the
17 paper, it's almost biased to the right side in
18 terms of the methodology, talking about docs
19 and events and resources.
20 And so you might want to, I can't
21 read the sentence, but, add in that -- can you
22 blow that thing up a little bit --

1 CO-CHAIR LOTZ: Sure.
2 DR. GOLDEN: -- so people can read
3 it? And it really changes what we do in some
4 ways. And I think -- well, my eyes are about
5 there, but not quite. I have the wrong
6 glasses on to do it. Sorry.
7 If you did something like resource
8 use measures are an important building block
9 to measures of efficiency of care and then add
10 and its organization. And you start getting
11 into systems. And you go beyond just talking
12 about a surgery. You start talking about how
13 you integrate what happens.
14 And that's why I think it's
15 important to start talking about what level of
16 the system and what level you want measures
17 for, because it changes some of the wording in
18 here. And it changes, it kind of broadens
19 some of the approach and some of the
20 methodology.
21 But I think we really want to talk
22 about how we are organizing care as part --

1 and if you want to analyze building blocks and
2 resource input, it's very different from say
3 doing a hernia operation and its follow-up
4 versus organizing care for episodes of
5 congestive heart failure or, for that matter,
6 even trauma.
7 CO-CHAIR LOTZ: Okay. Tom?
8 DR. ROSENTHAL: I think one of the
9 things the group is struggling with a little
10 bit is this idea that what we know we have to
11 do is work on the resource use and, yet, we
12 all really desperately want it to all get
13 linked to efficiency quickly.
14 Maybe one way to acknowledge that
15 would be, in fact, to switch the paragraphs
16 around and put the efficiency thing right at
17 the top, that that is one of the five IOM
18 quality domains. It is critical. But at the
19 moment, we are missing the resource piece.
20 And certainly what resource and
21 quality measures exist aren't integrated in a
22 fashion the way Jack Needleman said. Then

1 maybe that would satisfy our sense that we had
2 put the proper emphasis on the thing and
3 define then what we are doing is resource use
4 being the building block.
5 When we say a building block to
6 what, we should have said the what first. So
7 maybe that's a modest compromise that might
8 assuage the group without changing the focus
9 of what we have to do.
10 But it does tell the story a
11 little bit better and I think what we are all
12 struggling with is these bullet points are so
13 bullet pointed that they don't feel like they
14 tell the story that we want to tell.
15 And, you know, when I am writing a
16 policy or something, sometimes brute force is
17 better than elegance. And so that would --
18 meaning say more, say what you need to say.
19 CO-CHAIR LOTZ: Bill Rich?
20 DR. WILLIAM RICH: I agree with
21 both Jack and Tom on these edits. I don't
22 have the same concern that Mary Kay does,

1 because I think we all devolved that the
2 implications of resource. I'm not sure the
3 white paper explicitly gets into, you know,
4 that concern of getting right into efficiency
5 measures.
6 I'm happy with the language. We
7 will see what happens as the day goes on, but
8 I didn't get that same overall impression that
9 we were dealing with the implications of
10 resource use, which is, obviously, the way
11 they are used now. But I may be wrong. So
12 I'm happy with the amended language and moving
13 on.
14 CO-CHAIR LOTZ: Lisa?
15 MS. GRABERT: I tried this
16 exercise several times when I have had the
17 brief leadership through several rounds of
18 regulation making when I was at -- when I was
19 writing the fee schedule when I worked at CMS.
20 And the thing that, I think,
21 always worked best at communicating what you
22 are trying to achieve here was a simple

1 equation. Efficiency equals quality measures
2 plus resource use measures.
3 And what we are trying to do in
4 this project is define the resource use
5 measures. And they are pretty clearly always
6 communicated to people where we were trying to
7 go and what we were trying to achieve.
8 So I think a simple equation may
9 suffice even bulleted language.
10 CO-CHAIR LOTZ: Steve?
11 MR. PHILLIPS: Yes. You know, I
12 guess, when I think back to the conversation
13 yesterday and, you know, if I were sitting out
14 there trying to develop a system that
15 accounted for some of these -- for resource
16 use, you know, I think what we touched on
17 yesterday that is a big problem is just
18 particularly when you are trying to put
19 together costs or resources from across
20 different settings.
21 You know, you have got -- if
22 everything is contained within the physician's

1 office, for example, you have, you know, RBUs,
2 you know, the payments or whatever. But, you
3 know, when you start getting into things --
4 services, for example, that there is no
5 current standardized measurement for, that
6 that creates some complications that the
7 developers are going to have to face.
8 And so I guess I would just offer
9 up that I don't really see a principle here
10 that just gets at that kind of obvious issue
11 in terms of standardization or comparability
12 across settings in dealing with services maybe
13 where there isn't currently a system in place
14 to value them.
15 CO-CHAIR LOTZ: Ethan?
16 DR. HALM: Yes. To follow-up on
17 that, I mean, I hear us struggling with the
18 fact that the majority of people want this to
19 be the Steering Committee on Efficiency
20 Measures. And so if this document is the
21 first thing people see and there is a nice
22 long white paper as a reference, I think we

1 need to make the resource use measure up
2 front.
3 I mean, it is important for its
4 own sake. We know that. We know we don't
5 want just that, but these are resource use
6 measures. And so I think we want to bring
7 some of the richness and detail about what we
8 mean by resource use, the different ways of
9 thinking about it, why it is important,
10 clearly, toward building towards efficiency is
11 important.
12 But it is important in and of
13 itself for health care delivery and financing
14 and payment. And it is a little odd to me to
15 define things by what it is not. So it's like
16 basketball, basketball is a sport played with
17 a ball. It's not baseball. It's not
18 football. But it is sort of related to
19 soccer. It is played with a team.
20 It's just let's be more explicit
21 about what we are meaning by resource use and
22 then we can worry about the language about

1 building block toward efficiency and some of
2 the provisos that we want to deal with.
3 But if I'm understanding this
4 correctly, this is the first thing people will
5 see, right? Are people really going to start
6 with the white paper and then go back to the
7 statement of bullet point principles or the
8 other way around?
9 MS. TURBYVILLE: So the first
10 thing, as Helen just noted, that people will
11 truly see is the call for measures, to be
12 honest, because the white paper won't be
13 finalized until November. But your point is
14 well-taken. This we anticipated putting this
15 in the white paper.
16 DR. HALM: In the white paper,
17 but --
18 MS. TURBYVILLE: Right. I think
19 but to Ethan's point is that they are going to
20 hone in on the bullets regardless of where we
21 put it.
22 CO-CHAIR LOTZ: David?

1 DR. PENSON: So now I will
2 wordsmith, because I think Lisa's comment
3 really helped me to think about this a little
4 bit. And you actually have the definition of
5 resource use measure up there already. It's
6 the amount of resource use per population or
7 episode or procedure. You have already read
8 that.
9 So whether or not you put
10 efficiency first or second, I think it's very
11 simple to just write resource use measure is
12 defined as the amount of resource use per
13 population or episode or procedure. A value
14 or efficiency, remember, efficiency is a
15 relative term, is defined as, I always put
16 quality in the numerator, but whatever,
17 quality divided by resource use or the other
18 way around.
19 But you have, basically, done it
20 already, Sally. It's there. And the first
21 line should be a resource use measure is
22 defined as the amount of resource used per

1 population or episode or procedure. I mean,
2 that's what it is.
3 And if you just go and you say
4 quality is separate, efficiency or value are
5 separate and this is a part of that and give
6 them the formula, you know, we can debate,
7 then we are done. And I think it's very
8 clear, straightforward. It distinguishes and
9 defines everything and I think it is easier.
10 CO-CHAIR LOTZ: Paul?
11 DR. BARNETT: I just think those
12 last edits are great and help a lot. But I
13 want to make sure that in the document we
14 don't forestall or dissuade anyone who has a
15 resource measure that really is -- or excuse
16 me, submitting a measure that really is about
17 efficiency.
18 For instance, if someone has an
19 index of inappropriate care that they want to
20 put forward, I think we would really want to
21 entertain looking at that. And that we
22 shouldn't do anything to discourage that from

1 actually looking at measures of inefficiency--
2 excuse me, measures of efficiency.
3 CO-CHAIR LOTZ: Joe?
4 DR. STEPHANSKY: I am always in
5 favor of simple declarative sentences. And I
6 think we are making this way too complex. I
7 would rather just take, as Tom suggested,
8 first, efficiency in the first bullet point.
9 The second bullet point, very simple, resource
10 use measures are measures of input. Then go
11 on to the third point that -- and end it right
12 where it says and ultimately understand
13 variation. Make it simple. And then I think
14 that still leaves things open.
15 CO-CHAIR LOTZ: Bruce?
16 CO-CHAIR STEINWALD: Am I next?
17 CO-CHAIR LOTZ: Yes.
18 CO-CHAIR STEINWALD: Okay. I
19 agree with everyone.
20 CO-CHAIR LOTZ: Then you don't
21 need to repeat everyone.
22 CO-CHAIR STEINWALD: All right. I

1 won't repeat it. Well, I'm making a plea for
2 some contextual consideration. As I
3 understand it, what the measure developers
4 have to meet are the criteria, right? So the
5 principles are here, you know, to kind of
6 inform the criteria or to help people
7 understand why the criteria are what they are.
8 So you know, as I have read
9 through this, I have said well, we could
10 wordsmith it. And I actually do agree that we
11 should wordsmith and simplify it and have
12 declarative sentences and maybe even a
13 formula.
14 But then make it clear that, and
15 it should be clear to us that, when you
16 develop and submit a resource use measure,
17 those measures are going to be held up against
18 the criteria and not a bunch of principles.
19 The principles are there to enhance
20 understanding, but they are not what the
21 measure developers have to meet in order to
22 qualify their measures. Fair statement?

1 So you know, that, to me, is kind
2 of a plea for trying to get past the
3 discussion of principles. I mean, the people
4 have to be satisfied that the principles are,
5 indeed, reflective of what we are trying to
6 accomplish, but what the measure developers
7 are going to have to focus on is the criteria.
8 So okay? I mean, I'm looking for
9 nods in either direction. Okay.
10 DR. BURSTIN: I just want to
11 follow-up on Paul's point, because I think it
12 is an interesting one. You know, we initially
13 conceived of this thinking this was really the
14 chance for us to bring in resource use
15 measures, not wanting to necessarily up front
16 put together saying this is the resource use
17 measure you should use with X outcome, that
18 perhaps that was just too much for where we
19 are right now.
20 And I would just be curious. I
21 think it's a discussion worth having. One
22 question might be if you look at the executive

1 summary that I passed out yesterday from the
2 Efficiency Measurement Framework that the
3 Steering Committee put together a couple of
4 years ago, one of the principles there, and
5 one thought might to be reiterate perhaps some
6 of the principles in that document here, is
7 inappropriate care cannot be efficient.
8 And I wonder if there is something
9 about trying to, I don't know, weave something
10 like that in that might be helpful? But I was
11 curious of some examples of perhaps some
12 measures that might be out there just to kind
13 of give us something more concrete to think
14 through.
15 DR. BARNETT: Well, people used
16 the ambulatory sensitive conditions as an
17 example.
18 CO-CHAIR STEINWALD: Well, let me
19 add to what you are saying. I very much do
20 agree with Paul that we wouldn't want to
21 discourage developers from submitting actual
22 efficiency measures.

1 And for example, if someone has
2 developed a measure that uses quality adjusted
3 life years or something like that, which are
4 in widespread use in other parts of the world,
5 we would hate for them to not submit it
6 because they saw this as an efficiency in the
7 measure, not a resource measure.
8 So, yes, we want to certainly be
9 inclusive of real efficiency measures.
10 CO-CHAIR LOTZ: Final comments?
11 Sally, you have got a couple of very concrete
12 things and a few less concrete concepts to
13 work with. Should we move on?
14 MS. TURBYVILLE: Yes.
15 CO-CHAIR LOTZ: Okay. Did you
16 want to get something to final now or continue
17 to play with it and then send something out
18 final?
19 MS. TURBYVILLE: No, I mean, I
20 think --
21 CO-CHAIR LOTZ: I go for the
22 latter.

1 MS. TURBYVILLE: -- this is what I
2 was able to do in the past few -- oh, sorry.
3 Just based on the conversation I have heard
4 here, initial kind of moving things around,
5 shortening the sentences, adding an equation,
6 figuring out the order a little bit better,
7 whether we go resource first or efficiency,
8 making sure that they flow, so does this seem
9 to be capturing?
10 DR. PENSON: Well, rather than say
11 with that person it is a measure of inputs,
12 why don't you just say it is resource use over
13 quality? I mean, that's really what it is or
14 quality over resource use. It's resource use
15 or like I said, I tend to do the other,
16 quality per resource use is how I tend to look
17 at it, but that doesn't necessarily mean I'm
18 right.
19 But basically, you know, NQF does
20 quality measures. So it is basically quality
21 by resource use.
22 CO-CHAIR LOTZ: All right. We are

1 going to need to move on conversationally.
2 MS. TURBYVILLE: Okay.
3 CO-CHAIR LOTZ: Mary Kay and then
4 if anyone has a burning last comment. Again,
5 you will see this via email over the next
6 couple of weeks, so you can continue to --
7 DR. O'NEILL: For me --
8 CO-CHAIR LOTZ: Mary?
9 DR. O'NEILL: -- the equation is
10 you have the inputs resource use per
11 population or whatever you are measuring
12 equals quality. And then you compare those
13 metrics in different situations for their
14 value, right?
15 I mean, it's input per population
16 has a specific outcome or product. And then
17 you compare those, right, to see who is
18 efficient.
19 CO-CHAIR LOTZ: Tom?
20 DR. ROSENTHAL: I'm sorry to
21 belabor it. And I like the order and I like
22 the simplicity and the declarative sentences

1 work really well. As I read the fourth bullet
2 point, however, I think we have changed the
3 meaning from where the discussion was
4 yesterday, because by saying the best
5 measurement effort should integrate explicit
6 quality and appropriateness measures, I think
7 we are sending a message to developers that,
8 in fact, you better submit an efficiency
9 measure.
10 CO-CHAIR LOTZ: Yes.
11 DR. ROSENTHAL: Whereas, what we
12 said yesterday over and over again was there
13 is an element of that being a future state.
14 And you could add in another sentence, but
15 maybe this is too much to add, that we lack
16 the resource measures.
17 I mean, we have had 10 or 12 years
18 of development of quality measures. Maybe
19 some statement that the whole purpose of this
20 exercise is to develop those resource unit
21 measures so that we can get to efficiency
22 measures.

1 But they for the most part are
2 lacking in a structured organized fashion.
3 Hence, the purpose of this entire exercise, as
4 I understand it.
5 CO-CHAIR LOTZ: Mary Kay, is your
6 card up again or not yet put down? Okay.
7 I'm going to have us move on. Oh,
8 sorry.
9 MS. PODULKA: There has been a
10 couple different discussions about how to
11 frame the equation of addition factor ratio
12 division and maybe rather than really tackling
13 exactly what we want the mathematical formula,
14 if we could say something simpler that
15 efficiency is a function of both quality and
16 resource use.
17 So function is implying an
18 equation, but we haven't really specified
19 which one we think is the right one to do.
20 CO-CHAIR LOTZ: All right. Let's
21 move on to the next couple of bullets. Let's
22 look at them as a group, because I think we

1 have discussed them in part. I mean, I don't
2 think anyone is going to debate the second
3 one, efficiency is one of the five IOM
4 domains.
5 We already did the third one
6 noting Jim's comment about the reference or
7 lack of a reference.
8 General comments about those two
9 bullets? Are you keeping up up there? No,
10 that's different.
11 CO-CHAIR STEINWALD: Well, we are
12 giving a nod to the --
13 MS. TURBYVILLE: Yes, because I
14 can't edit when it is expanded. That's the
15 problem, that's why I keep on going back and
16 forth.
17 CO-CHAIR STEINWALD: You've got a
18 copy of the slides and it is in there.
19 CO-CHAIR LOTZ: Well, she has
20 changed them.
21 CO-CHAIR STEINWALD: Well --
22 CO-CHAIR LOTZ: The slides are no

1 longer relevant.

2 CO-CHAIR STEINWALD: Yes.

3 CO-CHAIR LOTZ: At least not for

4 that first bullet. So can you go to the

5 fourth bullet, there is continuum of types of

6 resource measures?

7 MS. TURBYVILLE: Yes.

8 CO-CHAIR LOTZ: All right.

9 Working from the handout, the Word document

10 that was in our folders when we arrived here

11 yesterday, there is a continuum of types of

12 resource measures, all types of resource

13 measures must meet evaluation criteria.

14 This is fairly standard NQF

15 language. So I'm going to say that we can't

16 really change that. It's probably good for

17 inclusion, but not really many degrees of

18 latitude around changing that.

19 The resource use measure

20 calculation must be explicitly stated in

21 transparent such that the approach can be

22 deconstructed and implemented in a standard

1 manner.

2 Lisa, the last bullet or the one I

3 just focused on?

4 MS. GRABERT: The first one. I

5 know we're dumping poor performance, but I

6 wonder if there is something in there that we

7 might want to capture about bending the cost

8 curve as a purpose for looking at resource use

9 measures?

10 CO-CHAIR LOTZ: Yes. Jim, use

11 your mic.

12 MR. WEINSTEIN: We talked about

13 unexplained variation and the notion of

14 bending the cost curve is related to that, I

15 assume, but you could say that definitively.

16 CO-CHAIR LOTZ: Do you know where

17 we are at, Sally?

18 MS. TURBYVILLE: I'm sorry, I got

19 distracted.

20 CO-CHAIR LOTZ: That's okay. This

21 is what Jim had mentioned before, using the

22 word poor.

1 MS. TURBYVILLE: All right. We
2 already did that.
3 MR. WEINSTEIN: Unexplained
4 variation.
5 CO-CHAIR LOTZ: Was the phrase
6 that he had used, unexplained variation.
7 MS. TURBYVILLE: Unexplained,
8 unexplained.
9 CO-CHAIR LOTZ: Yes.
10 MR. WEINSTEIN: Hard to explain
11 unexplained.
12 CO-CHAIR LOTZ: Any other
13 comments? Lisa, is your card still up or you
14 are done? Okay. All right.
15 Why don't we move on from there.
16 This is a little bit hard for me.
17 MS. TURBYVILLE: Where are you at?
18 CO-CHAIR LOTZ: No, we are in the
19 same place. Resource use measure must be
20 transparent, able to be deconstructed and
21 implemented in a standard manner. Tom?
22 DR. ROSENTHAL: A quick question,

1 I'm sorry, on the previous one.

2 CO-CHAIR LOTZ: Okay.

3 DR. ROSENTHAL: Will it later be

4 explained what continuum means or is it -- in

5 other words is it efficient here to say there

6 is a continuum of types of resource going?

7 When I read that cold, I'm not sure I would

8 know what the heck that means.

9 CO-CHAIR LOTZ: So I think that

10 was building off the diagram that we spoke to

11 at great length yesterday and --

12 DR. ROSENTHAL: No, I --

13 CO-CHAIR LOTZ: -- recommended

14 changing.

15 MS. TURBYVILLE: Right.

16 CO-CHAIR LOTZ: Right.

17 DR. BURSTIN: This is in

18 isolation.

19 CO-CHAIR LOTZ: Yes, yes.

20 DR. ROSENTHAL: I'm just asking

21 the question of if in isolation and this is

22 the first thing one --

1 CO-CHAIR LOTZ: Yes.
2 DR. ROSENTHAL: -- reads, is it --
3 CO-CHAIR LOTZ: Does it still make
4 sense?
5 DR. ROSENTHAL: Or is it
6 sufficient to refer to it later and then
7 somebody can go to page 7 and go oh, here is
8 what they mean.
9 CO-CHAIR LOTZ: Okay.
10 DR. ROSENTHAL: Or do we need to
11 say something as simple as by this we mean
12 capitated, fully capitated populations all the
13 way from two episodes of care to individual
14 procedures or is that --
15 CO-CHAIR LOTZ: Just be a little
16 more explicit, is what you're saying?
17 DR. ROSENTHAL: That's all I'm
18 saying.
19 CO-CHAIR LOTZ: All right. Bill
20 Rich?
21 DR. WILLIAM RICH: Hold on for a
22 second.

1 CO-CHAIR LOTZ: Okay. Steve?
2 MR. PHILLIPS: You have -- it
3 seems like there is a word missing now where
4 it says "ultimately, understand unexplained
5 variation and performance in regards," is it
6 variation and performance? I'm not sure what
7 we are getting at now with that.
8 The variation was in cost, wasn't
9 it or variation of resource use?
10 CO-CHAIR LOTZ: I think it's the
11 end and in unexplained variation in
12 performance?
13 MR. PHILLIPS: Or wouldn't it be
14 resource use or performance or some variation?
15 CO-CHAIR LOTZ: Sorry, I've lost
16 my thread here. Bill you want to pass?
17 Steve? Oh, you're no longer up. Dolores?
18 DR. PENSON: No.
19 CO-CHAIR LOTZ: No? We don't
20 quite have this yet? Jim, you want to wade in
21 again? This is something that you had started
22 us off with a couple of comments ago.

1 MR. WEINSTEIN: Well, I think
2 variation in practice deals with resource
3 utilization, deals with performance, all of
4 the issues, so I think you could leave it, as
5 you have an understanding on unexplained
6 variation and performance regarding our
7 specific mission here of this Committee.
8 So I think that deals with that.
9 CO-CHAIR LOTZ: Ethan?
10 DR. HALM: Yes. I mean, I think
11 these resource use measures are going to be
12 important in building blocks towards
13 efficiency and trying to understand
14 unexplained variation. But it seems to me
15 that there are lots of people, lots of
16 organizations who wanted to use resource use
17 measures for other things besides just
18 explaining unexplained variation.
19 And I don't see this definition
20 reflecting that. Right? I mean, presumably
21 there are more cost effective ways of
22 delivering care that could be completely

1 appropriate and there is no variation but one
2 way is cheaper than the other for the same
3 outcome.
4 I mean, everything for systems
5 delivery organization payment, I mean, the
6 unexplained variation story is incredibly
7 important, but it is not the only reason
8 people for 5 or 10 years have been doing this,
9 you know, in their own backyards.
10 CO-CHAIR LOTZ: Yes.
11 MR. WEINSTEIN: Or in large
12 corporations. So it would be nice to reflect
13 the justification and intended purpose for
14 these measures to include some of what we know
15 to be out there.
16 I worry when we send this out to
17 the public people will go like what the hell
18 are you guys talking about?
19 CO-CHAIR LOTZ: Yes.
20 MR. WEINSTEIN: We're in it for
21 this. It maybe inappropriate in some cases,
22 but there are lots of other appropriate uses

1 of this besides just looking at unexplained
2 variation and performance.
3 CO-CHAIR LOTZ: Jeptha?
4 DR. CURTIS: Yes, a couple of
5 points. Just first, I think unexplained, I'm
6 not sure why that needs to be in there. Like
7 why can't you just say ultimately understand
8 variation? And I would also get away from
9 performance and get back to practice.
10 Performance implies quality, to me, and
11 practice is what we are actually observing and
12 what the units or the different resources used
13 are.
14 And then just more getting back,
15 sorry, you said burning questions, and I
16 missed my opportunity earlier, but the -- what
17 I want to get closure on is this call for
18 measures going to include efficiency measures
19 or not?
20 Because if we have a white paper
21 that doesn't provide the outline for that and
22 we don't have the metrics for evaluating

1 efficiency measures at our hands when we take
2 this to the TAPs and we take this back to the
3 Steering Committees for vote, I don't know
4 what we are going to be judging on. And it
5 will be, I think, arbitrary.
6 So I think I would strongly think
7 that we need to stay on target with resource
8 use measures or maybe evaluate half of
9 efficiency measures, the resource use half.
10 I don't know. But I don't know if we can
11 broaden it at this stage without a major
12 change in the white paper focus.
13 CO-CHAIR LOTZ: Barbara?
14 DR. RUDOLPH: Well, I was going
15 back to the --
16 CO-CHAIR STEINWALD: Microphone.
17 DR. RUDOLPH: -- idea of
18 unexplained variation performance. And I
19 think it is more than that. I mean, as
20 purchasers, we are looking to reduce excess
21 cost.
22 CO-CHAIR LOTZ: Yes.

1 DR. RUDOLPH: And appropriate
2 costs of health care. And not just explain
3 the variation. We have already been doing
4 that for a while.
5 CO-CHAIR STEINWALD: Okay. I have
6 a suggestion for you.
7 CO-CHAIR LOTZ: Okay. I'll put
8 you in line. Jeff?
9 DR. JEFFREY RICH: Sorry. I think
10 the unexplained is an important adjective
11 there, because there is explained variation in
12 cost of health care. There is geographic
13 variation, I think. If we just say variation,
14 I like the modifier unexplained, because it
15 allows us to have variation in health care
16 costs across the country. But I like to know
17 that there is some unexplained variations.
18 And I agree that we need to stay on target
19 about resource use and not efficiency
20 measures.
21 CO-CHAIR LOTZ: Bruce?
22 CO-CHAIR STEINWALD: Well, my

1 wordsmith would be justification and intended
2 purpose for resource use measures is to
3 examine, understand and ultimately reduce
4 unnecessary cost of health care. And I'm
5 thinking that that gets it.
6 All right. After the word
7 examine, I would say examine, understand, and
8 ultimately reduce unnecessary costs of health
9 care. Let's see if that does it for you. See
10 if they buy it.
11 DR. GOLDEN: We can't further
12 criticize it until it's up on the screen.
13 MS. TURBYVILLE: The pressure is
14 on and I'm not a good typist.
15 DR. GOLDEN: Examine, understand
16 and ultimately reduce unnecessary, two ns,
17 costs of health care. I'm not real big on the
18 unnecessary. All right. Because, you know,
19 in some ways, if you look at things like
20 comparative effectiveness, you have different
21 ways of doing business and you get different
22 results depending -- and it's not necessarily

1 -- it is comparable as values.
2 And unnecessary seems to indicate
3 there is an absolute way of doing something
4 and that if you don't need to spend the money.
5 But you could deliver services different ways
6 and get different levels of outcomes,
7 depending on what your values are to those
8 outcomes.
9 CO-CHAIR STEINWALD: I would be
10 okay with getting rid of unnecessary.
11 DR. GOLDEN: Yes. We make
12 decisions all the time.
13 MS. TURBYVILLE: Is it health care
14 system or was it something more --
15 DR. GOLDEN: Yes.
16 MS. TURBYVILLE: -- specific than
17 that?
18 DR. GOLDEN: It is a little bit
19 value laden, that makes me uncomfortable.
20 CO-CHAIR LOTZ: Jeff and Jeptha.
21 Jeff, are you still up from before or you have
22 new comments? All right. Tom?

1 DR. ROSENTHAL: We are on a path
2 that either we can go down one of two ways.
3 One of which is to try to explain either in
4 detail or in some very carefully crafted
5 wordsmithed way why we are doing this.
6 I think the risk of it is is this
7 whole discussion about whether the word
8 unnecessary belongs in the definition or that
9 we haven't captured the eight other reasons
10 why people would want to do this.
11 The other alternative to this
12 entire thing is we teed up that efficiency is
13 a value. You have got to understand the cost
14 in order to be able to say anything at all
15 about efficiency. And we don't attempt to
16 write a paragraph or a bullet point or
17 anything else on exactly what the
18 justification is.
19 I must say the best single line
20 though that I have heard, Bruce, was yours and
21 I think you have got to have the word
22 unnecessary because we are not just trying to

1 reduce costs in the health system, we are
2 trying to reduce unnecessary cost.
3 But I think we are down a path
4 that may trip us up in a whole variety of ways
5 that we would be better off not being tripped
6 up in. So that's just an alternative
7 suggestion.
8 CO-CHAIR STEINWALD: If we want to
9 keep the word unnecessary, we can add
10 unnecessary variation in cost. But I take
11 your point that do we really need to do this?
12 CO-CHAIR LOTZ: Especially in
13 light of the first bullet, which we have
14 massaged quite a bit. All right. Helen
15 doesn't have her mic on, but what she is
16 saying is just delete it. Ethan, comment?
17 DR. HALM: Yes. So one thing you
18 could do is just put a backslash between un
19 and necessary, so it could be unnecessary or
20 necessary.
21 CO-CHAIR LOTZ: I don't know,
22 Ethan. I think the consensus was just drop

1 the darn thing.

2 DR. HALM: Well, the --

3 CO-CHAIR LOTZ: Or the almost

4 consensus.

5 DR. HALM: Well, I mean, I think

6 we -- I don't -- we can drop it here, but I

7 think the point that some of this is about

8 trying to reduce the cost of care.

9 So you know, I liked the

10 suggestion, so ultimately, reduce, you know,

11 costs. You know, you can also -- another

12 formulation would be ultimately reduce cost of

13 care, you know, and improve efficiency.

14 But I think to lose the fact that

15 this is not really all about trying to do

16 something about, you know, measuring and

17 reducing costs or being able to do more with

18 the same resources, gets away from the real-

19 world purpose and application of these things.

20 CO-CHAIR LOTZ: We were asked to

21 do some moderate wordsmithing today. But I do

22 think we need to move on as well. And I think

1 it is hard with the last suggestion to say
2 well, why don't we drop it completely, unless
3 you have all the bullets in front of you.
4 So unless there is one or two last
5 burning comments about this particular bullet,
6 the cost being one of them, including some
7 concept of cost, let's put that in for
8 consideration when you can see them all
9 together and move on with the next couple of
10 bullets.
11 So if you would just make sure you
12 capture that, Sally, and then we will move on.
13 All right. With regard to this
14 next bullet, the comment was already made
15 about elaborating on what a continuum is,
16 because as a bullet here it is in isolation
17 from the rest of our conversation.
18 CO-CHAIR STEINWALD: We could just
19 put an e.g. in there.
20 CO-CHAIR LOTZ: Use some examples.
21 MS. TURBYVILLE: Well, in the
22 background document itself, we actually put

1 the continuum diagram, the one that was --
2 where it was removed from the White Paper, but
3 I think that's a good idea to make sure we
4 reference it.
5 CO-CHAIR LOTZ: Let's move forward
6 from there. All right. So the resource must
7 be explicitly stated, transparent,
8 constructed, deconstructed and implemented in
9 a standard manner. Again, this is pretty
10 standard NQF language. But if anyone has --
11 oh, sorry, Bill Rich?
12 DR. WILLIAM RICH: There are a
13 couple of things that we discussed in detail
14 yesterday that I don't know where they fit in
15 here. Are they referring back to the
16 evaluation criteria? And I think reliability,
17 stability and, to go back to Paul's point, of
18 costing.
19 And if this thing is just
20 constructed without understanding rapidly
21 changing billing and patterns of
22 administrative code, you can have tremendous

1 distortions if we don't -- if the measure
2 developers don't consider that.
3 If you look at the fastest growing
4 things in health care now are office-based,
5 non-facility diagnostic testing. The
6 difference in payment, based on site of
7 service, is 48 percent for evaluation of
8 management code, by Bill, whether he is an
9 employed physician in an ACO on a hospital
10 premises.
11 So I think that making -- asking
12 them to be aware and explicitly state how they
13 arrive at their costing is very important.
14 And it goes beyond Mary Kay's point yesterday
15 of just collecting RBUs. When you translate
16 that to dollars, they have to be very
17 explicit, because the difference is huge.
18 It's 46 percent.
19 So I think we have to ask them
20 somewhere to make that plain to us in the
21 application.
22 CO-CHAIR LOTZ: I think that's

1 going to be under the specific criteria that
2 we are going to move to. I have made a note
3 of it, but don't let anyone around the table
4 forget it. But I think that's where it
5 becomes a very specific directive to the
6 measure developers to say tell us how you did
7 this in great detail.
8 So let's not lose that. Jeff?
9 DR. JEFFREY RICH: Yes. The
10 second bullet point, I think, needs to be
11 clarified based on our conversation yesterday
12 and Tom's principle of measure first and
13 monetize second. You are asking them just to
14 monetize from the beginning and I think that
15 in order to understand the measure developers
16 construct better, you would want to know what
17 they are measuring and how they monetize that.
18 And I'm not sure of the exact
19 wordsmithing to use here, but I think it has
20 to be consistent with what is going to appear
21 in the white paper and Tom's principle of
22 measuring first and monetizing second. I

1 would certainly like to know how they develop
2 the measure.
3 CO-CHAIR LOTZ: Tom?
4 DR. ROSENTHAL: Thank you, yes.
5 CO-CHAIR LOTZ: Hang on. Sally,
6 did you want to ask something?
7 MS. TURBYVILLE: Yes. So the
8 purpose of this bullet, you know, perhaps it
9 needs to change, but was to send a signal that
10 we want them when they are developing a
11 measure to first have a concept of what it is
12 they are measuring. This gets to validity.
13 And then that they demonstrate through what
14 they submit that, indeed, that is what they
15 are measuring.
16 So perhaps cost is the wrong word,
17 but that they actually -- that there is
18 something they are trying to measure first and
19 then they develop the measure and they come
20 back and they are making sure that they are,
21 indeed, measuring that with the final score
22 and various resource units that they have

1 picked.

2 So we want to measure total costs

3 of care in outpatient facilities, so we are

4 selecting these resource units to measure

5 that. And they should be the selection of

6 those individual service categories should be

7 justified by what they are trying to measure

8 of the outpatient.

9 So you know, we can do away with

10 this or perhaps it is not clear as stated, but

11 that was the intention as a principle.

12 DR. ROSENTHAL: I must confess.

13 It wasn't clear to me what we were trying to

14 say. I thought we were trying to say what the

15 comment was and then secondly, I think we

16 heard from Tom Lee yesterday that it is not

17 entirely clear that we want things rolled up

18 into one score.

19 We might want to understand the

20 richness of something without it having to be

21 rolled up in one score and that it could be

22 both dollars and stuff as opposed to just one

1 dollar figure, because this implies again that
2 the major purpose of this is so that people
3 can be arrayed on a grid. And that may or may
4 not be the right use for the thing.
5 CO-CHAIR LOTZ: Well, I think at
6 one point that was the purpose, but we are
7 pushing the envelope on that. Mary Kay?
8 DR. O'NEILL: I just wanted, I
9 guess, to say, again, that I think the cost
10 shouldn't be the leader, because the value and
11 applicability of these measures across a lot
12 of different situations will be more robust in
13 counting inputs and then monetizing later,
14 because costs vary, reimbursement varies, all
15 kinds of things vary.
16 And so starting with that, it
17 really particularizes the measure to a
18 specific place in the system. So I think
19 counting -- starting with cost is probably
20 misleading.
21 CO-CHAIR LOTZ: Yes.
22 DR. O'NEILL: I think I know what

1 you are saying about saying we want to
2 understand how the resource is utilized, but
3 if we start cost means dollars, and dollars in
4 one place vary considerably than dollars in
5 another for the same inputs.
6 CO-CHAIR STEINWALD: Okay. You
7 don't need the phrase of cost.
8 CO-CHAIR LOTZ: You have to speak
9 into the mic.
10 MS. TURBYVILLE: Right.
11 CO-CHAIR STEINWALD: Sorry. My
12 suggestion would be to remove of cost, because
13 we are talking about resources.
14 PARTICIPANT: But does it really
15 have to be rolled up into one score?
16 CO-CHAIR LOTZ: Yes, we still have
17 the concept of one score that I think is a
18 good suggestion to eliminate in some way.
19 CO-CHAIR STEINWALD: I have one
20 suggestion.
21 CO-CHAIR LOTZ: No. We are here.
22 Go ahead. Mary Kay is not -- she just spoke.

1 She just hasn't put it down yet.
2 CO-CHAIR STEINWALD: All right.
3 CO-CHAIR LOTZ: Yes, so go ahead.
4 CO-CHAIR STEINWALD: How about a
5 subordinate clause? How about resource use,
6 you want to start with conceptual construct,
7 right? How about if the measure is
8 constructed from a set of components or a set
9 of services, the methods used to do that have
10 to be developed and tested and justified.
11 You know, the idea is you could
12 have a single measure that doesn't have a
13 roll-up, but if you do have a roll-up, you
14 have to justify the components and the
15 construction of it.
16 CO-CHAIR LOTZ: Go ahead, Joe.
17 DR. STEPHANSKY: All right. Given
18 that we are going to go on to more explicit
19 criteria, to me this sounds like something we
20 could leave out all together.
21 CO-CHAIR LOTZ: Yes.
22 CO-CHAIR STEINWALD: Okay.

1 CO-CHAIR LOTZ: Yes, yes.
2 CO-CHAIR STEINWALD: Fine.
3 CO-CHAIR LOTZ: All right. Again,
4 the suggestion again was made that maybe we
5 don't need this and since that's hard to do in
6 isolation without seeing all of the principles
7 and maybe not moving forward a little bit,
8 too, when we get to the specific criteria,
9 let's put that out there. Last comment on
10 this bullet, otherwise we will move on to the
11 last two bullets and then we will take a
12 break.
13 All right. Let's move on to the
14 next couple of bullets. I think that will
15 have to be expanded. Can you do that?
16 MS. TURBYVILLE: Yes.
17 CO-CHAIR LOTZ: All right. You
18 have them on your handout. While Sally works
19 on creating a tool that we can look at, the
20 next bullet that we are on is combining
21 multiple score service -- providing multiple
22 service categories into one resource use

1 estimate increases complexity; using
2 methodologically sound methods is one of
3 paramount importance.
4 The approach should be fully
5 transparent. I think we said that already.
6 Furthermore, even though the background
7 calculations may be more complex, the final
8 resource use score or result should be simple
9 and readily interpretable by all stakeholders.
10 Those sentences aren't readily
11 interpretable and simple. So let's start with
12 that.
13 You know, I'm going to start the
14 conversation by saying that again, I think a
15 lot of this is already an inherent part of the
16 NQF process. I think we have said some of it
17 already, again, hard to see in isolation.
18 Anything essential in here? Barbara?
19 DR. RUDOLPH: Well, I guess, I
20 have a question about the scope. If someone
21 is measuring say oh, the quality or the
22 resource use in diabetes care, if they fail to

1 roll-up the whole series of costs or resource
2 units or whatever, most people on a TAP would
3 say that they actually failed to adequately
4 capture, you know, the resources used to treat
5 that diabetic patient.
6 So without having some kind of
7 multiple service category into the model or
8 the concept or the construct, they are going
9 to have a hard time passing sort of the test
10 of validity.
11 CO-CHAIR LOTZ: Yes.
12 DR. RUDOLPH: So I think while
13 these things sound complex, not saying them
14 may lead toward -- may lead measure developers
15 to bring in little onesy measures of, you
16 know, okay, I'm going to measure just the cost
17 of the insulin for diabetic patients. And
18 that would be inadequate.
19 CO-CHAIR LOTZ: Yes.
20 DR. RUDOLPH: So I know these
21 things are complex, but I think somehow you
22 have to capture this complexity somewhere and

1 talk about it and talk about the way that you
2 want them to be able to deconstruct it or to
3 be able to explain how they put all these
4 various components together.
5 So I'm not sure we should just get
6 rid of all this language is what I'm saying.
7 CO-CHAIR LOTZ: Jack?
8 MR. BOWHAN: I think all of it is
9 complex and we do have to be transparent about
10 that, which we have stated in multiple places.
11 And I think the actual principle here that we
12 want to state is that the final resource
13 scores should result in a simple and readily
14 interpretable by all stakeholders, that's the
15 important part.
16 The rest of this is all complex.
17 They still have to meet all the criteria that
18 it goes through.
19 MS. TURBYVILLE: The delete button
20 is where the page down button is on this
21 laptop, and it's driving me crazy.
22 DR. CURTIS: While Sally is

1 working on that, let me just make a point or
2 call a point. I think Barbara brought up the
3 issue that where possible these measures
4 should take the broadest point of view
5 possible. And I think that is actually a
6 reasonable principle to have explicitly stated
7 somewhere in these bullets.
8 I don't think we are capturing
9 that anywhere else in here and I think it
10 should be.
11 MS. TURBYVILLE: I'm sorry, I
12 missed your comment.
13 CO-CHAIR LOTZ: What should we
14 make sure we capture?
15 DR. CURTIS: I think as a
16 principle, it should be that these are broad--
17 take the broadest view possible, you know.
18 MS. TURBYVILLE: Yes.
19 CO-CHAIR LOTZ: And, Tom?
20 DR. ROSENTHAL: That was going to
21 be my point.
22 CO-CHAIR LOTZ: So I think that's

1 where we get into more of a concept of
2 principle as opposed to --
3 DR. ROSENTHAL: Well, frankly, I
4 mean, you could start this paragraph with the
5 idea that comprehensiveness is preferable.
6 CO-CHAIR LOTZ: Yes.
7 DR. ROSENTHAL: In making it
8 comprehensive, however, you may end up with a
9 somewhat more complicated framework.
10 CO-CHAIR LOTZ: Yes.
11 DR. ROSENTHAL: Therefore, you
12 really must, you know, kind of end up with
13 something though that is demonstrably simple
14 for stakeholders.
15 CO-CHAIR LOTZ: Yes.
16 DR. ROSENTHAL: I mean, that tells
17 the story.
18 CO-CHAIR LOTZ: Jeptha, is your
19 card still up or up again? Sally, do you want
20 to play with that for a while? Do you want to
21 move on?
22 MS. TURBYVILLE: Sorry?

1 CO-CHAIR LOTZ: Yes.
2 MS. TURBYVILLE: I think this is,
3 I'm hoping, getting to what I have heard. So
4 kind of adding more clearly that comprehensive
5 measures are preferable, talking about even if
6 it is complex, it should still be sound. So
7 we want to make sure they are still hitting
8 all the rigor. And that maybe teasing out,
9 regardless of any approach, any final resource
10 use score should be interpretable.
11 And that's part of our criteria,
12 but I think given the area and the type of
13 measures I have seen, it may be worthwhile to
14 have a principle. Your call.
15 DR. HALM: Can we use the word
16 measure instead of score?
17 MS. TURBYVILLE: Sure, I think.
18 DR. HALM: As a more general term.
19 CO-CHAIR LOTZ: All right. Some
20 nods around the table. Let's move on to the
21 last bullet. And then there are a few
22 scattered comments that may or may not lend

1 themselves to principles, so I want to make
2 sure we don't lose sight of that from the
3 category of do we need any new principles.
4 So the last one, you've got two. I
5 only have one on my sheet. Nevertheless, the
6 comment about methods, Jack?
7 DR. NEEDLEMAN: Yes. This
8 language looks like it came from talking about
9 bundles of quality performance, process
10 measures and does not seem appropriate to this
11 particular set of measures. All or nothing
12 scoring indicates whether patients receive all
13 or less than all the items measured. That's
14 not what the resource measure is about.
15 That's what bundles are about.
16 CO-CHAIR LOTZ: So are you
17 suggesting eliminating it as a principle for
18 the resource use?
19 DR. NEEDLEMAN: At least the
20 parenthetical remark. And, you know, the
21 question is whether -- and I don't know the
22 answer to this. I would like to see what we

1 wind up getting is whether we want the
2 resources unbundled, so we understand the
3 different components of resources that have
4 gone into the aggregate resource use to
5 understand what some of the possible sources
6 of variation might be.
7 So the concept of bundling or
8 unbundling the resources goes back to some of
9 our earlier conversations makes sense, but
10 talking about all or nothing does not make
11 sense in the context of the measures we are
12 talking about.
13 CO-CHAIR LOTZ: Barbara?
14 DR. RUDOLPH: This is actually a
15 question for Helen. If a measure developer
16 were to put in there sort of construct
17 different cost -- different resources, say for
18 again diabetes, medications and whatever else,
19 eye exams, whatever, would that be a composite
20 or would it only be a composite if it was
21 weighted? Like if you weighted some of say
22 the eye exam more heavily than you weighted

1 the cost for the insulin.
2 DR. BURSTIN: It's actually a
3 really good question, Barbara. It's not an
4 easy answer. Unfortunately, to date our
5 composite framework defines a composite as two
6 or more measures combined into a single score.
7 So the question would be are those actually
8 individual measures or are those just
9 components where you are really just summing
10 up to get to a total cost?
11 And I think that is going to be
12 something we will have to see how these play
13 out. I don't know that we have a clear answer
14 yet.
15 DR. RUDOLPH: Okay.
16 DR. BURSTIN: Yes. I would tend
17 to think they are not composites and they are
18 just literally additive notions where you are
19 not combining. Unless, for example, you are
20 taking -- making separate scores of saying,
21 for example, an episode of care would be the
22 cost of prehospital care/hospital care where

1 there is an actual separate score for each,
2 that's where I think weighting and issues like
3 that come into play and make it more like a
4 composite.
5 DR. ROSENTHAL: The only question
6 about whether there should be one other
7 principle and I'm not sure if there should or
8 whether this even makes any sense, but
9 yesterday we had a lot of conversation about
10 the difference between payments made to arrive
11 at a cost versus the actual cost.
12 Is there a principle there that
13 has to be enunciated somewhere early on in the
14 game that those that use real -- there would
15 be advantages to those that use real cost as
16 opposed to simply what is paid? It comes back
17 to the accounting first and counting things
18 first and then monetizing it second.
19 Does that get played out in the
20 detailed instructions later? And maybe I'm
21 being incredibly vague and unclear on that.
22 CO-CHAIR LOTZ: No. I don't

1 think. I think that is what Bill Rich was
2 getting at earlier as well. And that would be
3 for you folks to somewhat say. Is there a
4 principle? Is there a guiding thought on what
5 to do with respect to the cost or let everyone
6 just report it as they will, but be explicit
7 about how you are going to report that. Go
8 ahead, Paul.
9 DR. BARNETT: So it all depends on
10 the perspective and what you are trying to do
11 with the analysis. So if you are the payer,
12 reimbursement is what matters. If you are the
13 provider, it's your actual cost that matters.
14 So I'm not sure.
15 CO-CHAIR LOTZ: So is some comment
16 about perspective necessary? Perhaps not in
17 the principle. We don't want to lose sight of
18 it when we get to the guidelines or the
19 criteria, rather.
20 DR. BARNETT: Well --
21 CO-CHAIR LOTZ: You know, that
22 someone should be explicit about the

1 perspective that they are submitting their
2 measure for use from. Bill?
3 DR. GOLDEN: I'm sorry. I have to
4 ask this. What are we trying to do here? I
5 mean, is this to give guidance to the
6 submitters?
7 CO-CHAIR LOTZ: This is to give
8 guidance to the submitters specifically to
9 think about the additional criteria beyond the
10 essential four that NQF has.
11 DR. GOLDEN: Right. I am
12 concerned that we are going from broad
13 principles to very weedy details. And I'm
14 just -- by going after one bullet at a time
15 and not seeing the whole package --
16 CO-CHAIR LOTZ: Okay.
17 DR. GOLDEN: -- I think we are --
18 I'm not sure we are accomplishing what we want
19 to do.
20 CO-CHAIR LOTZ: I think that's a
21 good point. Mary Kay, are you up new? Paul,
22 are you not yet down? Okay. So Mary Kay,

1 Bill. We are coming up to a break and at the
2 break, I think, we are going to change gears.
3 Well, if we can complete this task, which we
4 may be very near to. Helen is nodding
5 vigorously over here.
6 There is a certain pain in
7 wordsmithing and getting to detail, but there
8 is a certain efficiency to not doing it by
9 email and letting everyone be in the room to
10 either nod or not nod. So with apologies to
11 the torcher, we are almost done with it. Mary
12 Kay?
13 DR. O'NEILL: So putting Bill's
14 point aside as to whether or not we should be
15 having these things under principles from an
16 efficiency standpoint, the viewpoint of
17 efficiency if it's the resource input from the
18 delivery side, you need to have some measures
19 with input costs from the delivery side.
20 I know that one of the chief
21 customers of this is HHS, so they are a payer,
22 so they would be interested in the inputs from

1 the payment side.
2 CO-CHAIR LOTZ: Yes.
3 DR. O'NEILL: So I think both
4 things from various viewpoints are valid from
5 an efficiency evaluation perspective. It just
6 would need to be explicit. And I don't know
7 if that's a principle or in the weeds.
8 CO-CHAIR LOTZ: Go ahead, Bruce,
9 you're next.
10 CO-CHAIR STEINWALD: To the point
11 about perspective, again, I don't know if it's
12 a principle, but it seems to me that the
13 measure developer ought to be saying something
14 about who the expected users of the measure
15 are and that gets you to perspective.
16 DR. WILLIAM RICH: I know we are
17 going to get into this later on, but to
18 follow-up on Paul's point, if you look at
19 total payments out, I think it's important for
20 even the individual provider to realize that
21 there are some hidden expenses to his
22 depending upon site of service as an

1 employment thing.

2 Again, the variation is about 45

3 percent. A lot of docs don't realize that.

4 So I don't think looking at it from the

5 payer's point of view, I think -- I don't

6 think those are exclusive, the physician side.

7 Most physicians don't realize the total cost

8 if they are en employed physician in a

9 hospital-based practice. They don't realize

10 what -- 50 percent is billed as a facility fee

11 on top.

12 So I don't think those are

13 mutually exclusive, Paul.

14 CO-CHAIR LOTZ: All right.

15 Several concepts came up as potentially new

16 principles and I'm going to toss them all out

17 there and see how you want to take things from

18 there. There is a concept of the idea of

19 saying something in the form of a principle

20 about the perspective.

21 I think that gets to an earlier

22 comment that Steve made about looking across

1 sites of service and how we standardize or
2 comment on that, the question about cost and
3 how to deal with various different ways of
4 looking at cost.
5 And oh, there was one more. Any
6 idea that we should include, if only by
7 reference, some of the work that the
8 Efficiency of Care Steering Committee had
9 done? So three potential new principles.
10 Want to make additional comments? Would you
11 like them to be -- like them not to exist?
12 Would you like to see Sally --
13 yes, I know. Hold you hostage for your break.
14 Have Sally mock something up based on the
15 disparate comments we have made to date on
16 those ideas and then comment via email? Go
17 ahead, Ethan.
18 DR. HALM: I think the perspective
19 one is important and then I would just expand
20 that umbrella to include some of what we
21 talked about yesterday of having the developer
22 articulate sort of the perspective of the

1 measure. Is it from the societal perspective,
2 the plan perspective, you know, the patient or
3 physician perspective? That's separate from
4 the sort of across all setting sites and
5 databases.
6 CO-CHAIR LOTZ: Bill Rich? Jeff?
7 DR. JEFFREY RICH: Should we also
8 include in the principles a statement saying
9 that measures should address as broad a
10 population as possible? I know we have talked
11 about it. I don't know that it's a principle.
12 I don't want measure developers to address a
13 very narrow population. Maybe they should, I
14 don't know, but I think as a guiding
15 principle, you want a measure that cuts across
16 many patients, not just a narrow segment of
17 the population.
18 CO-CHAIR STEINWALD: I think
19 that's covered by importance. But, you know,
20 I think it's important, but I think it's
21 covered.
22 CO-CHAIR LOTZ: Go ahead, Tom.

1 DR. ROSENTHAL: Maybe we have
2 enough principles.
3 CO-CHAIR LOTZ: We are very
4 principled. All right. Again, it's not your
5 opportunity for final comment, but I think for
6 today we have had enough.
7 I just want to remind folks that
8 Kurt is on the phone with us. Kurt,
9 apologies, we didn't really use the slides
10 much. We sort of created our own, which you
11 can't see.
12 DR. ELWARD: No, thank you. I
13 have been listening.
14 CO-CHAIR LOTZ: But thanks very
15 much for being on the phone. We won't forget
16 that you are there, but we are going to take
17 15 minutes.
18 DR. ELWARD: Okay. I will be
19 here.
20 CO-CHAIR LOTZ: And when we
21 return, we will talk specifically about our
22 criteria that we will put out in the call to

1 measures. Kurt, you should have the handout.
2 We're going to actually use that side-by-side
3 table, so you can follow using that table that
4 was in the handouts.
5 DR. ELWARD: Resource Use
6 Committee, it's this updated evaluation
7 criteria?
8 CO-CHAIR LOTZ: Exactly.
9 DR. ELWARD: Okay. Great.
10 Thanks.
11 (Whereupon, at 10:34 a.m. the
12 above-entitled matter went off the record and
13 resumed at 10:49 a.m.)
14 CO-CHAIR STEINWALD: Kurt, are you
15 still there?
16 DR. ELWARD: Yes, I am.
17 CO-CHAIR STEINWALD: Good. You
18 should have that side-by-side in front of you.
19 Okay.
20 DR. ELWARD: Yes, I see it.
21 Thanks.
22 CO-CHAIR STEINWALD: Okay. So

1 now, we are going to launch into our
2 discussion of the criteria that our measure
3 developers will have to meet in order to have
4 a successful resource use measure accepted.
5 And the handout is coming. Just
6 as a reminder, the side-by-side on the left
7 hand side are existing criteria and sub-
8 criteria for quality measures. On the right
9 hand side are adaptations of what is on the
10 left hand side for resource use measures.
11 And our task is to examine what is
12 on the right hand side and decide whether we
13 think the adaptation works or doesn't work.
14 Are there things that are unnecessary or
15 things -- and certainly things that are
16 missing that should be in the sub-criteria for
17 resource use measures.
18 You will notice or I noticed at
19 least that the word quality still exists
20 frequently on the right hand side. And I
21 think one of our issues will be to decide
22 whether we want to maintain that or more

1 aggressively, if that's the right word,
2 replace the word quality with efficiency or
3 another resource use concept term.
4 So that's my preamble. Would
5 anybody like to say anything of a general
6 nature before we launch into the specific
7 criteria? Oh, yes, Helen would.
8 DR. BURSTIN: Just one comment.
9 We really do think these criteria, for the
10 most part, should still work at a very high
11 level. And what we are really interested in
12 is given your knowledge of where this field is
13 in terms of resource use measures, are there
14 just some adaptations of language or some
15 specific sub-criteria that would need to be
16 thought about slightly differently that we
17 want to change it?
18 We don't need a wholesale new set
19 of criteria.
20 CO-CHAIR STEINWALD: Right.
21 DR. BURSTIN: I just want to make
22 sure we emphasize these work quite well. We

1 just want to think about how to make them work
2 even better for these kinds of measures.
3 CO-CHAIR STEINWALD: Yes, please,
4 do. And describe also what you just handed
5 out. Go ahead.
6 MS. TURBYVILLE: Okay. I'm going
7 to describe what I just handed out and then
8 one logistical question.
9 So what I handed out are the
10 various analytic steps that we discussed
11 yesterday that a resource use measure
12 typically walks through. What you will notice
13 is, as you get towards the bottom half of the
14 page, many of those tend to be more flexible
15 for users, so a measure developer may say,
16 depending on your perspective, you may
17 attribute the results this way or that.
18 So as we move through the
19 criteria, I would like the Steering Committee
20 to keep in mind these various analytic steps
21 and whether they need to be explicitly called
22 out for a particular sub-criteria or whether

1 or not they wouldn't necessarily be subject to
2 the evaluation.
3 So if all are fine as they are,
4 then I don't think we necessarily have to go
5 into detail on each one. But if somehow it is
6 a little bit nuanced or different for a sub-
7 criteria, I think it's important that we send
8 that signal to the measure developers, so that
9 they know exactly what they are submitting to
10 us in detail.
11 Did you want to add to that?
12 CO-CHAIR LOTZ: Well, as we were
13 chatting after the meeting yesterday, you
14 know, Helen created kind of a dichotomy of
15 thought that I wanted to share with the
16 Steering Committee as well.
17 In thinking about what is
18 essential about these criteria that we are
19 about to review, what is essentially a part of
20 the measure and what might we want to put as
21 guidance? What might we want to put that the
22 measure developer should provide as guidance

1 to the folks that will implement this measure?
2 So again, the dichotomy being what
3 has to be a part of the measure and what is
4 part of the implementation and how does that
5 reflect as we look at these criteria.
6 You know, you may want to say this
7 is not an essential part of the measure, but
8 the measure developer should speak to how to
9 apply it.
10 CO-CHAIR STEINWALD: Jeff, your
11 card is up. Did you intend that? Okay.
12 Why don't you do ahead. This is
13 an administrative note.
14 MS. TURBYVILLE: So I apologize to
15 interrupt the more thoughtful discussion that
16 is about to happen.
17 There was a request to take a poll
18 and those who are going to Dulles and we
19 could, you know, potentially then all could
20 take a Super Shuttle there together. It's a
21 long trip. So anyone going to Dulles? Okay.
22 Did you get that? Okay. All right. Thank

1 you.

2 CO-CHAIR STEINWALD: Okay. What

3 is up there is the first of the main criteria

4 is importance and the sub-criteria on the left

5 and right, quality versus resource use. Any

6 comments on the first segment of that? Yes,

7 ma'am. I say yes, ma'am, because your card is

8 not turned to my direction.

9 DR. RUDOLPH: Oh.

10 CO-CHAIR STEINWALD: Barbara.

11 DR. RUDOLPH: Sorry. My only

12 concern with this one was that because we are

13 looking at the resource use as a component

14 down the line of efficiency, I'm wondering if

15 some of the resource use measures on their own

16 will actually meet the importance to measure?

17 DR. BURSTIN: Let me answer that.

18 And that was why we actually explicitly, I

19 thought, or maybe this didn't reflect some of

20 the updated discussions we have had, Sally,

21 said that importance to measure and report in

22 this context would be just that there is high

1 cost or variation in cost.
2 Is that in here now?
3 MS. TURBYVILLE: It's already in
4 there. So for example, affects large numbers,
5 leading cause of morbidity/mortality, high
6 resource use current and/or future. So that
7 first part, I didn't change at all, because I
8 thought that it was --
9 CO-CHAIR STEINWALD: Yes, Tom and
10 then David.
11 DR. ROSENTHAL: Well, but I think
12 that the confusion I had is that those are the
13 elements that, in fact, informed our entire
14 conversation for the last day and a half and
15 I think I would leave with them. I think --
16 and the other elements that I heard here of
17 sort of importance would be to the extent that
18 the measure is comprehensive, to the extent
19 that the measure is applicable across larger
20 groups, to the extent that the measure moves
21 towards the left side of the spectrum.
22 I mean, that has been the basis.

1 And so I think we should lead with those on
2 the right hand side to contrast it with the
3 importance of the quality measures. I don't
4 think it is enough to have them buried in a
5 parenthesis.
6 CO-CHAIR STEINWALD: To make sure
7 I understand, what are you saying we should
8 leave with exactly?
9 MS. TURBYVILLE: Well, just one
10 quick thing just to make sure. When there is
11 no bold or italic, nothing has been changed.
12 So the two first paragraphs match each other.
13 It is exactly how it was written before.
14 So for example, if we scroll down,
15 we can see there is a bold of poor performance
16 because I had heard before this dislike for
17 that word for resource use. And not to
18 discredit your comment. I just want to say
19 that when there is no bold or italic, it is
20 because it is matching exactly what we already
21 had in place, which was the premise to first
22 go with what we have and then see where we

1 need to make changes.
2 DR. ROSENTHAL: Well, again, I
3 guess then and not trying to be critical, but
4 since the first thing one is going to read on
5 the right hand side is well, what's the
6 importance to measure and report on resource
7 use measurement? I would lead with those
8 things. Severity, you know, high cost,
9 widespread variation, applicability across
10 geographies, applicability -- which is
11 different than just copying off from the left
12 hand side of what we currently are using for
13 quality measures.
14 I would just lead with that,
15 that's all.
16 CO-CHAIR LOTZ: Well, an
17 orientation question for Sally and Helen. My
18 understanding is we can't take away any of the
19 criteria that NQF has already, but we can
20 amend it.
21 DR. BURSTIN: I mean, I think what
22 Tom is actually saying is there is additional

1 guidance --

2 CO-CHAIR LOTZ: Yes.

3 DR. BURSTIN: -- beyond what is on

4 the screen for the quality measures around --

5 MS. TURBYVILLE: For different

6 prioritization or different order.

7 CO-CHAIR LOTZ: So is that

8 something that can be done or does the actual

9 architecture of NQF's four basic criteria have

10 to stay the same? And all we can do is add?

11 DR. BURSTIN: We can highlight

12 what is most important up front, that's fine.

13 DR. HALM: I mean, I was going to

14 say the same thing. This is where all of our

15 discussion should be reflected. So whether or

16 not we have to maintain all of this, but, you

17 know, the extent to which the specific measure

18 focus is important to making significant, you

19 know, decisions about, you know, reducing

20 cost, improving efficiency, resource

21 allocation, payment, planning, other things,

22 that's the whole raison d'etre for these

1 measures. And it should be reflected here.
2 I mean, you know, maybe we defer
3 to you guys to figure out how you want to
4 handle this, so that you don't upset the case
5 law of all the quality measures on sort of,
6 you know, principle number one. But we should
7 have a straightforward measure about the
8 importance.
9 And then something that came up
10 vis-a-vis relating to importance yesterday is
11 this is perhaps where the perspective of the
12 measure comes into the importance that we want
13 the developers to say this is important, you
14 know, from the perspective of the plan or the
15 physician or the payer or society in framing
16 it.
17 CO-CHAIR STEINWALD: David?
18 DR. PENSON: Yes. Sally, if you
19 go back to the top there, I mean, it is -- I
20 understand you have taken it verbatim as sort
21 of a template and jumping off point, but, I
22 mean, you are not -- these measures don't

1 measure quality. That's not what they do.
2 So that first sentence is to the
3 extent which the specific measure is important
4 to make significant gains in health care
5 quality, it's not what we are talking about.
6 It's what Tom is talking about. It's wrong.
7 It's the extent to which these
8 measures can ultimately result in significant
9 gains for all the things we have talked about
10 vis-a-vis efficiency, vis-a-vis, you know, a
11 higher quality of lower cost health care.
12 But to say it is significant in
13 health care quality, I mean, we can't just
14 willy nilly put those things together. And I
15 guess there are going to be changes there.
16 Because we all will say it's
17 important to measure and report, but the
18 difference is that we are not measuring
19 quality here.
20 MS. TURBYVILLE: My question would
21 be whether we are going to end up with two
22 distinct criteria or if we are trying to come

1 up with the criteria that encompasses resource
2 use, which I think initially the thought was
3 we want one criteria evaluation that, whether
4 it is quality or resource use, they could use
5 and it would encompass and add to as needed,
6 but that, you know --
7 DR. BURSTIN: I think we just want
8 to get it across to the developers that the
9 health care criteria remain. Those four
10 criteria are still the hallmark of what we do.
11 And as I look at this, maybe the way to do
12 this, rather than just block and copying, is
13 to actually just say, you know, in some ways
14 I think it would be pretty easy to say the
15 extent to which the specific measure focused
16 is important to making significant gains in
17 efficiency and where there is variation or
18 high resource use, period.
19 I mean, we have already kind of
20 stated that through the course of the last
21 couple days. I think we could really hone in
22 on what about this is explicit for efficiency

1 -- resource use measures in the context of
2 efficiency? Which is right. It's exactly
3 what we have been talking about for the last
4 couple of days.
5 CO-CHAIR STEINWALD: So just to
6 make sure we understand, so it would be
7 permissible in that second line to change the
8 word quality to efficiency and then make sure
9 that the rest of the statement comports with
10 that.
11 DR. PENSON: But again, efficiency
12 is quality over cost or it's a relative term,
13 so maybe efficiency is -- I mean, ultimately,
14 the extent to which the specific measure is
15 important in assessing ultimate health care
16 costs. Yes, I think that's what it boils down
17 to is we're talking about costs here.
18 And it ultimately may be useful
19 for efficiency, but that gets into the concept
20 of is it important that it tracks to a quality
21 measure? Which I think everyone in this room
22 would like to see that.

1 CO-CHAIR STEINWALD: Tom and then
2 Jeff. Jeff and then Jack.
3 DR. JEFFREY RICH: I think I
4 whispered that in his ear. I think if you
5 wanted to change that significant gains in
6 measuring health care costs, that's what we're
7 talking about here. We're not talking about
8 efficiency, because we already said we are
9 moving away from efficiency.
10 So we don't have a lot of good
11 measures of health care costs, so we want to
12 make significant gains in measuring it.
13 DR. BURSTIN: Just one more
14 response here. Much of this language is
15 really about the measure focus. It's about
16 the diabetes. It's about the heart failure.
17 It's not about the type of measurement.
18 So I don't want us getting too
19 lost here. Much of this is really saying it's
20 a priority or it's care coordination, it's
21 diabetes, it's heart failure. It's not that
22 it is efficiency versus outcomes.

1 CO-CHAIR STEINWALD: Jack?
2 DR. NEEDLEMAN: As I said in the
3 phone call, I think the importance issue is
4 while the measure sponsors have to, you know,
5 make the case, I don't think this is going to
6 be at all an issue in our deliberation.
7 So I'm happy to see the broader
8 IOM language maintained and then we can
9 specifically say the particular measures focus
10 here have to more forward our understanding of
11 resource use as part of improving the -- you
12 know, with the long-term goal of improving the
13 efficiency and quality of health care.
14 CO-CHAIR STEINWALD: Let me try
15 restating that a little bit. You know, if we
16 were starting from scratch, if there were no
17 quality measure criteria and we were just
18 focusing on efficiency and resource use, our
19 language might be something different than
20 what is here.
21 But since it is additive to the
22 criteria that NQF already uses, there is no

1 harm in maintaining a lot of that language and
2 then adding to it, because the measure
3 developers will understand that context. Is
4 that fair? Okay.
5 DR. BURSTIN: I think the key
6 piece of it here we wanted to get across was
7 that there wasn't an expectation that is part
8 of this you had to demonstrate that this
9 measure in and of itself would improve the big
10 bucket of quality.
11 We are accepting the fact that
12 being able to demonstrate this is a high cost
13 area is enough. And that's, I think, all we
14 wanted to get across in this. And I think we
15 probably have enough to kind of play with it
16 a bit and just make that point.
17 CO-CHAIR STEINWALD: All right.
18 Any other comments on the first block? If
19 not, can we move to the --
20 DR. BURSTIN: Just one question
21 getting back to Jim's point earlier. I wonder
22 here, Jim, since it specifically says here

1 whether the site demonstrated high impact
2 aspect of health care morbidity, et cetera.
3 It says high resource use current
4 and/or future. And I wonder here if it might
5 be appropriate to say high and/or unexplained
6 variation and resource use? Because I think
7 there may be times when high may not be
8 enough, but if there is -- and it may be okay,
9 but there may be examples where it is kind of
10 moderate, but huge variation and that might be
11 another reason, I think, to bring it up to
12 importance. Just getting back to your point.
13 DR. NEEDLEMAN: Yes. And just to
14 reinforce that, there will be times when low
15 resource use may actually be a concern. So
16 variation rather than focusing simply on
17 spending too much, sometimes we've got to
18 worry about spending too little.
19 CO-CHAIR STEINWALD: Jeff, your
20 card is up.
21 DR. JEFFREY RICH: I guess the
22 third box down on the right, did we drop the

1 poor performance language in there?

2 CO-CHAIR STEINWALD: Well, we are

3 still on the second.

4 DR. JEFFREY RICH: Oh, I'm sorry.

5 CO-CHAIR STEINWALD: I was just

6 moving to the second block.

7 DR. JEFFREY RICH: That block,

8 okay. Thank you.

9 CO-CHAIR STEINWALD: Okay. Now,

10 to me on that second bullet, the patient

11 societal consequences of inefficiency would

12 work better for me, because it brings in both

13 the cost and quality concepts.

14 But I'm also happy with leaving it

15 if leaving it has, you know, some asset value.

16 Any thoughts?

17 All right. Now, let's go to the

18 third block.

19 DR. BURSTIN: The third block, I

20 think, it's sort of the same language where it

21 is demonstration of high resource use or

22 unexplained variation in resource use, and

1 opportunity for improvement. So even in the
2 absence of knowing the quality issue, there is
3 still high or unexplained variation of
4 resource use and that's enough to pass the
5 initial criterion here for importance.
6 CO-CHAIR STEINWALD: And
7 substitute that for poor performance.
8 CO-CHAIR LOTZ: Or just say
9 inappropriate resource use. Again, I'm --
10 MS. TURBYVILLE: What was that
11 language from before?
12 CO-CHAIR LOTZ: All high is not
13 bad. Low can also be bad. Wrong kind can
14 also be bad.
15 CO-CHAIR STEINWALD: Jeff?
16 DR. JEFFREY RICH: Just back to
17 the first box. You had resource use, you put
18 there variation. Shouldn't it be unexplained
19 variation? Is that what you meant, Helen? In
20 the very top? The edits did not reflect that.
21 That we have up on the screen.
22 The top box. In the first box.

1 No, actually, I meant the first box. All the
2 way up. High or unexplained variation.
3 DR. PENSON: Do you need the term
4 high? Why don't you just say unexplained
5 variation? I mean, high, I know that's what
6 we are concerned about overuse, but there is,
7 as we talked about, under-use. If you just
8 say unexplained variation, it captures both
9 and it's not as slanted.
10 DR. BURSTIN: We're trying to get
11 examples where it may be uniformly high and
12 you don't see variation and that might still
13 be something that would be important to look
14 at.
15 DR. JEFFREY RICH: Yes, that's a
16 good point.
17 DR. BURSTIN: That's all.
18 MS. TURBYVILLE: Variation in
19 quality.
20 DR. JEFFREY RICH: Yes, you're
21 right, you're right.
22 CO-CHAIR STEINWALD: Paul?

1 DR. BARNETT: I would just say
2 this is about importance. And so we want to
3 focus on the things that are costly. I mean,
4 the diseases and the -- right? And so if it's
5 trivial and unexplained, we don't really care.
6 This is about importance.
7 CO-CHAIR STEINWALD: Anything else
8 on the third block? Are we agreed that we are
9 going to substitute the poor performance
10 language?
11 MS. TURBYVILLE: Right.
12 CO-CHAIR STEINWALD: Yes, okay.
13 MS. TURBYVILLE: So that's why it
14 kept on popping up, because I wanted to make
15 sure that it was --
16 CO-CHAIR STEINWALD: Okay.
17 MS. TURBYVILLE: -- put to bed, so
18 to say. And I think we did that in the last--
19 earlier in the morning.
20 CO-CHAIR STEINWALD: Okay. So
21 let's then move to page 2 or page 4.
22 CO-CHAIR LOTZ: So, Kurt, we are

1 on 1C now.

2 CO-CHAIR STEINWALD: 1C, good.

3 I'm glad you said that.

4 DR. ELWARD: Okay. Thank you.

5 CO-CHAIR STEINWALD: I have a

6 question, which is -- yes, sir?

7 PARTICIPANT: The phone.

8 CO-CHAIR STEINWALD: The guy on

9 the phone? What about him? He can't hear?

10 PARTICIPANT: He was saying

11 something.

12 CO-CHAIR STEINWALD: Oh. Kurt, go

13 ahead, please.

14 DR. ELWARD: Well, actually

15 earlier, I just had a question about one, but

16 I emailed you and I can -- you can mail me

17 questions when we were looking at talking

18 about efficiency, there might be resources

19 which actually do directly relate to quality

20 like diabetes education and asthma education,

21 things that might actually may not affect

22 "efficiency" either way, but may be

1 instructive as far as the appropriateness of
2 resources used.
3 CO-CHAIR STEINWALD: Okay. You
4 said that you had already sent an email with
5 that point?
6 DR. ELWARD: Yes.
7 CO-CHAIR STEINWALD: Yes, okay.
8 DR. ELWARD: Yes, I sent that out.
9 CO-CHAIR STEINWALD: Thank you.
10 DR. ELWARD: You can review that
11 when you have time. Thank you.
12 CO-CHAIR STEINWALD: Okay. 1C. I
13 have a question of what is the purpose of the
14 reference to scientific acceptability here,
15 since that's the next criterion?
16 MS. TURBYVILLE: So it's a good
17 question. I had to ask the same question.
18 The hope is that during the measure importance
19 rationale, justification that the measure
20 developer is submitting, they are describing
21 the intent of the measure enough so that then
22 when we look at scientific -- the scientific

1 acceptability, that they link and so then the
2 measure is validly measuring what they
3 intended it to do.
4 And so that was a recommendation
5 that included in the importance is what are
6 you trying to measure. And then as you review
7 the scientific acceptability, it should
8 resonate with what they said they were going
9 to measure.
10 So there are examples in quality
11 measures that have been received where they
12 talk about the importance of measuring this
13 and that and then the Steering Committee goes
14 in to look at the measure and it has nothing
15 to do with what they said was important to
16 measure.
17 They missed the boat somehow. So
18 that was why there was a request to add some
19 language there. So that's the purpose and you
20 can --
21 CO-CHAIR STEINWALD: All right.
22 Jeff and then Doris. Doris?

1 CO-CHAIR LOTZ: This is where I
2 see some ask to say in commenting on why the
3 measure is important, tell us from whose
4 perspective, so that this idea of perspective
5 we have gone back to, I think, needs to be
6 reflected here and explicitly asked.
7 CO-CHAIR STEINWALD: Jack?
8 DR. NEEDLEMAN: Related to the
9 issue of from whose perspective do we want
10 people to explicitly talk about potential uses
11 of the measure as a vehicle for assessing its
12 importance, for communicating its importance.
13 CO-CHAIR STEINWALD: You think the
14 two should be addressed simultaneously?
15 DR. NEEDLEMAN: Well, in the case
16 of -- yes. In the case of other, you know,
17 quality measures, you know, the uses are now
18 fairly standard, you know, potentially. But
19 in this case, if you say it is intended for
20 health plan use or it is intended for
21 physician use or intended for patient use,
22 that's the perspective we are taking in the

1 measure. Exactly how do you anticipate those
2 folks using it is an element of thinking
3 through can you get there from here?
4 Is this measure apropos what Sally
5 said about importance, will -- can the measure
6 be used as you are anticipating using it,
7 given the way you have constructed it, seems
8 to me to be part of the, not the feasibility
9 issue, but, importance issue.
10 DR. HALM: It's a question of
11 language in that 1D. Would you change that
12 language?
13 CO-CHAIR LOTZ: Paul, you have to
14 use your mike.
15 DR. BARNETT: No, 1D does it.
16 Just missed it.
17 CO-CHAIR STEINWALD: Well, it's
18 way down on the page there. All right. But
19 I guess the question is still on the table.
20 What do we think about the way that 1C is
21 framed? Is it okay or should we be focusing
22 on what is in 1D as opposed to what is in 1C?

1 Yes, Barbara?
2 DR. RUDOLPH: I was just thinking
3 that, I mean, if we think this should be in
4 here, it should probably be in here for
5 quality measures as well, because it is not
6 often -- the same kind of issues come up with
7 quality.
8 MS. TURBYVILLE: I think that came
9 from Karen. Some of the initial guidance.
10 This project is bumping up, you know, the
11 Testing Committee and the Task Force, I'm
12 sorry. And if I recall correctly, I borrowed
13 this from some proposed additions to the
14 quality side.
15 CO-CHAIR LOTZ: Because it seems
16 appropriate --
17 CO-CHAIR STEINWALD: I'm sorry,
18 what?
19 CO-CHAIR LOTZ: It seems
20 appropriate to both.
21 CO-CHAIR STEINWALD: Okay. Talk
22 into the mic, I think is the message there.

1 Go ahead.
2 DR. GOLDEN: One of the -- a
3 little concern about 1C would be that we are
4 kind of asking for a partial measure. We are
5 not asking for an efficiency measure. We are
6 asking just for the building block. And so it
7 may be very difficult for somebody to answer
8 1C if they are just offering you a building
9 block.
10 So it gets a little complicated
11 because we are not necessarily asking for a
12 complete item.
13 CO-CHAIR STEINWALD: The first
14 part of 1C, it seems to me, is already
15 covered. That is you have to explain and
16 justify the importance. So do we need 1C at
17 all? And you are saying that the comment
18 about well, if we have that for resource, why
19 not for quality, and you had said that well,
20 it is being added as a quality?
21 MS. TURBYVILLE: And I would say
22 that that's probably based on experience where

1 measures have been submitted that there has
2 been confusion based on what they had said it
3 was supposed to be measuring and then when
4 they look at the actual measure, it doesn't
5 meet.
6 So I think there was a desire
7 based on the experience to explicitly request
8 that information from the measure developer.
9 It does seem redundant, but I guess it's more
10 based on experience. There was a request to
11 call it out like we need to know exactly in
12 the beginning what you intend to measure.
13 DR. BURSTIN: Part of this is that
14 this week, literally tomorrow or the day after
15 the CSAC is going to be reviewing the final
16 report on the Evidence Task Force, all the
17 comments that came in, and making some final
18 determinations. So we may actually just need
19 to come back to this, to 1C, after that is
20 concluded next week.
21 DR. NEEDLEMAN: But we can be
22 smarter than other committees, right?

1 DR. PENSON: I do think you need
2 this. You know, I think you do. You know,
3 this is a place where you can, you know, talk
4 a little bit about the perspective, you know.
5 Does it -- is it important to the payer, to
6 the patient? You know, and you could
7 potentially also talk a little bit about that
8 bucket concept, you know, are you getting into
9 validity a little bit, but are you, you know,
10 capturing all the resource use for your area?
11 I mean, I think you need this,
12 Bruce. I don't think we can cut it out.
13 CO-CHAIR STEINWALD: Well, we have
14 an advocate. Why don't we agree to keep it
15 for the time being at least?
16 Now, we have a number of N/As and
17 I guess we ought to at least look quickly to
18 see if we agree that what is on the left hand
19 side is not applicable.
20 Yes, okay, I'm happy. I'm happy
21 until we get down to -- my footnote is ever
22 since the IOM defined efficiency as an element

1 of quality, I feel like every conversation is
2 a game of Twister, you know, where you put
3 your arm on one color and your foot on another
4 color and eventually you get twisted up.
5 And you know, because there is
6 this unavoidable circularity of using terms to
7 define concepts that then are used to define
8 the terms.
9 So now, that's a statement of a
10 problem and not a solution, so I'm hoping that
11 you will offer some. Yes, David?
12 DR. PENSON: Yes. I'm with you on
13 that. That's the best analogy I have heard,
14 a game of Twister, too. That's great. I'm
15 going to use that by the way. I'm not going
16 to give you credit either. Academics are a
17 nasty business.
18 No, I think you want to keep
19 efficiency here. And I think this is an
20 opportunity for us. You don't want to use
21 that verbiage, but I think this is the
22 opportunity to say while it's not mandatory,

1 you know, resource use measures which track to
2 quality measures and could ultimately be used
3 as an efficiency measure will be given added
4 emphasis or will be considered more important.
5 This is an opportunity for us to
6 actually, you know, push people along to that
7 next step, which is, okay, we know this is a
8 building block, but, you know, ultimately, we
9 want to get at efficiency. And if you can
10 show us that this ties to a quality measure or
11 that you ultimately see it tieing to a quality
12 measure, we are going to really weigh that
13 heavily in our deliberations.
14 CO-CHAIR STEINWALD: Doris?
15 CO-CHAIR LOTZ: So perhaps we take
16 our principles and use them very pragmatically
17 here and adopt some of the language there and
18 then again just emphasize that greater weight
19 will be given or a greater sense of
20 prioritization will be given if you can make
21 that link more compellingly.
22 CO-CHAIR STEINWALD: Any other

1 thoughts? General agreement? Jack?
2 DR. NEEDLEMAN: Yes. One could
3 just, as long as we are wordsmithing, say
4 well, we do not anticipate that resource
5 measures will fully realize the goal of
6 measuring efficiency. Priority will be given
7 to those that -- whatever language we wind up
8 filling in the blank there with.
9 So we can emphasize the importance
10 of trying to move towards the efficiency, but
11 also make clear we are not evaluating these as
12 efficiency measures per se, and we don't have
13 an expectation that they will necessarily be
14 full-blown efficiency measures.
15 CO-CHAIR STEINWALD: Yes. I kind
16 of like David's approach that we have stated
17 that resource measures are a building block.
18 Tell us how. And the more convincing you are
19 about that, the better off you are.
20 MS. TURBYVILLE: Who is they?
21 CO-CHAIR STEINWALD: The measure
22 developers.

1 Do you have enough guidance?
2 MS. TURBYVILLE: Yes.
3 CO-CHAIR STEINWALD: Okay. Let's
4 move on. 1D, it's just that one statement.
5 DR. HALM: So this might be --
6 didn't people talk about how this was going to
7 be applied? And is this the bullet that would
8 get at that?
9 CO-CHAIR STEINWALD: Well, yes.
10 What we talked about earlier --
11 DR. HALM: Because that makes
12 sense, whether we want to split it out here or
13 if we have already said it elsewhere. But I
14 think, you know, we want to say how it is
15 going to be applied and sort of --
16 CO-CHAIR STEINWALD: Yes. Well,
17 as Sally has pointed out, we have a lot of
18 redundancy and we hope that it is constructive
19 in the sense that reading it a second time is
20 going to help the developers, not harm them.
21 Here, though what we were talking
22 about earlier, is the uses and the users. We

1 might want to elaborate a little bit here if
2 it's not covered elsewhere and just maybe add
3 the purpose and objective and who the intended
4 users of the measure are.
5 MS. TURBYVILLE: It seems like it
6 might be in 1C or 1D. And as we put it
7 together, we will try and make it the best.
8 CO-CHAIR STEINWALD: Okay. Are we
9 ready to move on to 1E?
10 Any comments? Yes, Bill?
11 DR. WILLIAM RICH: This is not
12 really clear to me. Does it really reflect
13 what we are asking them to be, very clear, on
14 how they cost out the or monetize the inputs?
15 And the verbiage really doesn't reflect our
16 discussion yesterday or earlier today.
17 Again, it was brought up by Mary
18 Kay and Paul and myself and Tom. And I just
19 don't think this makes clear to the measure
20 developer what we are asking them to do. It
21 has to be very clear, you know, that they give
22 -- if they are going to just count inputs or

1 if they are taking inputs and monetize them,
2 did they -- what did they use? Did they use
3 a Medicare-base? Did they use site of service
4 differentials? Again, this has huge, huge
5 input on the physician level for any report.
6 CO-CHAIR STEINWALD: Paul and then
7 Bill.
8 DR. BARNETT: So I agree with the
9 last comment. I just wonder whether this
10 whole section actually belongs in the Part II,
11 the scientific acceptability. It doesn't
12 really belong in Part I, Importance.
13 CO-CHAIR STEINWALD: Okay. Bill?
14 DR. GOLDEN: Yes. This measure
15 really covers the material, I don't know if
16 everyone on the Committee has seen the
17 original Rand Report on efficiency that came
18 out about two or three years ago, but they
19 emphasized the importance of perspective.
20 And this measure by itself does
21 not cover the perspective issue. So some of
22 these items, you know, the laboratory

1 services, et cetera, et cetera, depends on the
2 perspective.
3 So if it was a DRG system, those
4 are irrelevant. If it's a hospital
5 administrator, they are relevant. It's
6 lacking that element here to define what we
7 need to include.
8 CO-CHAIR STEINWALD: Dolores and
9 then Bill.
10 MS. YANAGIHARA: The way I was
11 reading this, it makes sense to me just saying
12 that all the parts of a measure need to be
13 consistent with the whole of the measure, that
14 whole conceptual construct. When you are
15 getting into what costing methodology you use
16 and all that kind of stuff, I think that goes
17 later. That is not part of this one. I think
18 this one is just that all the pieces belong
19 and that they are part of that whole and they
20 are consistent with that whole concept.
21 CO-CHAIR STEINWALD: Bill Rich,
22 did you put your card down, because she said

1 what you were going to?

2 DR. WILLIAM RICH: It still

3 doesn't make sense to me.

4 CO-CHAIR STEINWALD: Okay. All

5 right.

6 DR. HALM: It's a confusing --

7 CO-CHAIR STEINWALD: Okay.

8 DR. HALM: -- set of words.

9 Confusing.

10 CO-CHAIR STEINWALD: Well --

11 DR. HALM: Refer to Dolores.

12 Dolores got it.

13 CO-CHAIR STEINWALD: Yes. All

14 right. He is getting really angry back there.

15 We've got to, you know, use those microphones.

16 I personally don't think it relates to the

17 criterion of importance. And I would prefer

18 that if there is content there that we need,

19 that we consider it as we move on. Can we do

20 that? Okay.

21 Scientific acceptability, Item 2.

22 The first block which isn't numbered --

1 MS. TURBYVILLE: The ones that
2 aren't numbered describe the criteria in
3 general terms. And then the ones that are
4 numbered, are then what the measure developer
5 must do in order to demonstrate that they are
6 meeting that criteria.
7 CO-CHAIR STEINWALD: Yes.
8 Comments? Paul?
9 DR. BARNETT: So this is where I
10 think the one that we are missing is, the one
11 that says where do you get -- is your measure
12 of resource use comprehensive? Does it -- is
13 it consistent? Is the technique that you are
14 using to monetize resource use consistent with
15 the perspective of the analysis?
16 You know, those issues, I think,
17 belong here and I don't think we have them
18 yet.
19 CO-CHAIR STEINWALD: Well, we have
20 got 2A through 2M. Do you believe that they
21 are not covered there somewhere?
22 DR. BARNETT: I believe that they

1 are not covered here, yes.

2 CO-CHAIR STEINWALD: Not covered

3 there, okay. Yes, well, let's go through what

4 we have got and then see if we can agree on

5 what is missing.

6 David.

7 DR. REDFEARN: Just in terms of

8 what the developers are going to deliver, are

9 they going to deliver a bunch of words that

10 are going to be evaluated partly on the extent

11 on which you can translate those words into a

12 computer program that executes the algorithms

13 that they want or are they going to deliver a

14 piece of software?

15 So is it the specification is

16 going to be objectified in a set of software

17 that they deliver or is it just words?

18 CO-CHAIR STEINWALD: I don't know.

19 Does anyone else know? Go ahead.

20 MS. TURBYVILLE: So, I mean, in

21 general, the specifications will allow a user

22 who gets the specifications to be able to

1 implement them. But for some of these more
2 complex commercial proprietary that would
3 approach it differently, they will have to
4 describe to us in words what their huge
5 software pseudo or maybe a pseudo-code or
6 something, but it is going to have to be in a
7 manner in which the Steering Committee can
8 understand the steps of the measures and then
9 they provide to us the information and
10 translation of the tests that they have
11 undergone to demonstrate the validity and the
12 reliability of the measure that they have
13 specified.
14 DR. REDFEARN: So they might give
15 us a flowchart or something like that.
16 MS. TURBYVILLE: Yes, yes.
17 DR. BURSTIN: So if you look at
18 the recent experience we have with our
19 clinically enriched initiative measures that
20 came from groups like Resolution Health or
21 Ingenix, the measure submission form was
22 completed with all the information. The

1 words, as you say, in addition to some of the
2 text, you know, the numerator end words, the
3 denominator end words and then there was
4 usually a pretty sizeable attachment that went
5 on for 50 pages of text and code and things
6 like that, just so, again, the people could
7 have the ability to take a deeper dive and
8 take a look if they needed to.
9 But the actual program itself was
10 not submitted and I think it is important to
11 remember that for some of these proprietary
12 vendors, they are going to have to submit what
13 people can read and they should be fully
14 transparent. That won't get put out for
15 public comment, unless the measure is
16 endorsed.
17 And then as I mentioned yesterday,
18 we do have this ability for them to have -- we
19 require them, if their measure is endorsed, to
20 put out a limited license to view, where you
21 could go in and look at the computer code, for
22 example.

1 CO-CHAIR STEINWALD: Okay. Any
2 others? Yes, Jeff and then Jack.
3 DR. JEFFREY RICH: Just sort of an
4 overarching question. How are we going to
5 deal with the difference in the measure based
6 on the measurement tool? I mean, all of --
7 somebody submits a measure using the Ingenix
8 or whatever measure tool, it would be
9 different if we used a different measurement
10 tool.
11 And how do we deal with that? Is
12 that a measure that we will feel comfortable
13 with if it's going to look different? You
14 know, if we endorse this measure, so we are
15 endorsing one product and one measurement tool
16 over others. I was a little concerned about
17 that as I read through some of this last
18 night.
19 DR. BURSTIN: That's a distinct
20 possibility. We honestly don't know if the
21 proprietary vendors are going to choose to
22 submit or not. If they choose to submit, we

1 will review them. This has come up before, on
2 our outcomes project we reviewed, for example,
3 the 3M methodology and things like that, as
4 well as Care Science. They got fully reviewed
5 and put out and ultimately they weren't
6 endorsed in that project. It doesn't mean
7 they wouldn't be endorsed in this project.
8 But again, I think this is -- I
9 think David has raised this issue several
10 times from the email exchange of how we handle
11 if potentially the different vendors come in
12 and there is different products.
13 DR. JEFFREY RICH: I mean, just as
14 a follow-up, I think on the quality
15 measurement arena we can specify a measure and
16 we can measure it in a variety of different
17 ways and have the same result. But in the
18 resource use measurement, the different tools
19 that we are going to use if we are using
20 groupers and things, they are going to yield
21 entire different results.
22 We are going to have a cacophony

1 of results for whatever measurement tool we
2 use.
3 CO-CHAIR STEINWALD: Jack and then
4 David.
5 DR. NEEDLEMAN: Well, I think the
6 issue that Jeff just raised is, you know, we
7 are -- you know, as part of what ultimately we
8 have to choose, we're going to have to decide
9 which measure works well enough that it is
10 ready for primetime and provides insight. And
11 there will be a cacophony. There will be
12 different measures of diabetes or whatever.
13 As I look at 2A and think about
14 the two elements that -- there are several
15 elements I'm going to need to look at to
16 decide whether a measure is working. And you
17 know, one is, first of all, I need to
18 understand what the focus of the measure is.
19 You know, are we going to be
20 looking at a grouper which produces 350 groups
21 and we have got to evaluate all 350, the
22 adequacy of all 350 encounter definitions for

1 how well they perform or are we looking at
2 specific encounters? Are we looking at a
3 diabetes, measure of diabetes use? You know,
4 we have got specific subcommittees organized
5 here.
6 So I think one of the questions I
7 have is what guidance are we giving the
8 providers on whether to give us a grouper that
9 is giving us 350 different definitions of
10 encounters or whether we are looking for
11 specific encounters around a half dozen or a
12 dozen types of conditions as well as per
13 capita resource use measures.
14 So at least they should tell us
15 what they are giving us, even if we are not
16 telling them what to give us. So that has to
17 do with focus of what the measure is.
18 DR. BURSTIN: The project does
19 include, sorry to interrupt, the project does
20 include a list of conditions --
21 DR. NEEDLEMAN: Okay.
22 DR. BURSTIN: -- and procedures as

1 a starting point plus per capita.
2 DR. NEEDLEMAN: Okay. So we need
3 to tell whether -- so that's the focus. And
4 they need to tell us whether they have gone
5 beyond that or not.
6 The other is how comprehensive the
7 definition of resources are, which we have
8 talked about yesterday. Do they include the
9 full range of resources that are being used in
10 care? Are they being measured explicitly?
11 Are they being measured implicitly? We know
12 we don't pay for, you know, consultations with
13 educators, but the physician payment sort of
14 is covering that. And maybe it is there and
15 maybe it isn't.
16 So the comprehensiveness of the
17 measure in terms of what resources it covers
18 is, to me, a second element. Then the
19 elements that are further down the list having
20 to do with appropriate adjustments to enable
21 comparability we believe in, about exclusion
22 rules and risk adjustments are also part of

1 this definition of getting a measure that is
2 comparable.
3 But the issue of the
4 comprehensiveness of the costs as a way of
5 assessing the comparability of measures is
6 something that is not here explicitly and
7 probably should be.
8 CO-CHAIR STEINWALD: David, did
9 you have something back on the other issue?
10 DR. REDFEARN: Yes. To come back
11 to the proprietary stuff, I have actually had
12 some conversations with Ingenix and since
13 Ingenix has such a reputation as being
14 litigious about these methods, I have to tell
15 you that they said that they are reading the
16 handwriting on the wall. And they realize
17 that these things have to go into the public
18 domain and they are willing to do so.
19 And I don't know how far they are
20 willing to do that. I doubt very seriously if
21 they are going to give away their code that
22 executes it, but I think they have already

1 made a lot of steps to put the methodology in
2 the public domain and I think they are willing
3 to go ahead and do that.
4 And that's fairly reassuring.
5 Some of the other vendors may react in a
6 different way, but I thought that -- surprised
7 me a bit from Ingenix. But I think what --
8 practically what is happening is they are
9 realizing the core groupers, they have to go
10 into the public domain. But they are going to
11 make their money with all the software they
12 wrap around the proprietary groupers to do.
13 So they are going to continue to
14 market the impact suite, but the groupers are
15 going to still be out there in public domain.
16 But that was reassuring, I thought.
17 CO-CHAIR STEINWALD: Okay. Moving
18 ahead.
19 MS. TURBYVILLE: Could I ask Jack
20 a follow-up question, please?
21 CO-CHAIR STEINWALD: Yes.
22 MS. TURBYVILLE: So for 2A when we

1 say that the measure will be well-defined and
2 precisely specified, you recommend that we
3 explicitly state that that includes the
4 resource units that will be measured?
5 DR. NEEDLEMAN: The resource units
6 and the scope of resource. It's the scope.
7 You know, so our drug expense is included in -
8 -
9 MS. TURBYVILLE: Right.
10 DR. NEEDLEMAN: -- the resources
11 that are being measured here or
12 hospitalization --
13 MS. TURBYVILLE: Part of for
14 example work? So I'm just concerned. I mean,
15 I think it is implicit in there, but I'm
16 sensitive --
17 DR. NEEDLEMAN: Yes.
18 MS. TURBYVILLE: -- that this is
19 new for some of the measure developers. So
20 I'm wondering if a for example would help?
21 That way we would just -- I would be worried
22 about missing something --

1 DR. NEEDLEMAN: Yes.
2 MS. TURBYVILLE: -- once we start
3 listing and if that would address the concerns
4 of the Steering Committee.
5 DR. NEEDLEMAN: Yes, yes. No, I
6 agree it's implicit. I just want to make it
7 explicit, because it will make it easier for
8 us to understand what we are being given.
9 CO-CHAIR STEINWALD: All right.
10 Just a moment here. So we have moved on to
11 2A. And we had a discussion yesterday about
12 phases. And as I recall, we decided not to go
13 that route. And so what Jack has proposed is,
14 basically, a substitute for what is in bold
15 there, as I understand it.
16 And others may have their own
17 views about what should be in there as well.
18 And I see Jeff, yours is still up, but
19 Dolores?
20 MS. YANAGIHARA: It seems like if
21 we are saying that it must be precisely
22 specified, that that's where this whole list

1 of requirements come in. If this is what we
2 want to see, I mean, that's where it shall be
3 listed.
4 CO-CHAIR STEINWALD: Yes, yes.
5 MS. TURBYVILLE: So the question
6 now for Steering Committee is not so much
7 which phases, but the steps within that were
8 previously phases, what needs on that list
9 need to be precisely specified for you to
10 evaluate the measure?
11 DR. HALM: So we should go back to
12 looking at this then?
13 MS. TURBYVILLE: Yes, that would
14 be helpful. The handout.
15 CO-CHAIR STEINWALD: Dolores? I'm
16 sorry, Doris?
17 CO-CHAIR LOTZ: A follow-up for
18 Jack. I'm curious to know since I don't play
19 in this world regularly, what degree of
20 granularity are you looking for? Take drugs
21 as an example. Do you want to know if drugs
22 broadly are in or out or do you want to know

1 which --

2 MS. TURBYVILLE: Well --

3 CO-CHAIR LOTZ: -- specific drugs

4 are in or out?

5 DR. NEEDLEMAN: Okay. So one of

6 the things that you see, for example, when

7 economists are looking at, you know, the cost

8 of treatment and different styles of providers

9 and the effect of health plan development on

10 use is we have got carveouts for the drugs

11 with one group and the mental health providers

12 in another group and shockingly the mental

13 health providers don't care how much is being

14 spent on prescriptions, because it is not in

15 their bundle and it's not in their cap rate.

16 So it's one thing to understand

17 the interaction of carveouts, but if you don't

18 have the drug costs in your data, you can't

19 analyze whether the carveout on the provider

20 side is influencing the way, you know, the

21 volume of drug costs.

22 And it is not a matter here, for

1 me it's not a matter, of I want to know the
2 way they put the measure together, how
3 comprehensive the costs are. We see lengths.
4 So I talk about drugs and mental health as two
5 different carveouts with two different sets of
6 people monitoring their use. That's one
7 example.
8 We could be seeing hospital
9 lengths of stay going down, because patients
10 are being, as we have seen, admitted to
11 skilled nursing facilities for post-
12 hospitalization rehab programs of various
13 kinds.
14 If we have got a measure that has
15 the hospital costs, but doesn't have the SNF
16 costs, we have -- and we are seeing hospital
17 costs being lower in one model than another,
18 I don't know what that means unless I know
19 whether the rehab is taking place inside one
20 set of hospitals for one measure and outside
21 for another.
22 So that's where understanding how

1 comprehensive the range of resources are that
2 are being reported becomes important in
3 analyzing the validity of the comparisons that
4 come out of the measure.
5 CO-CHAIR LOTZ: So is your comment
6 just asking for folks to be explicit in how
7 comprehensive they are or are you advocating
8 to be as comprehensive as hospitals?
9 DR. NEEDLEMAN: Okay. I would --
10 as -- the latter. Okay. I would say that my
11 preference is when we turn into reviewers of
12 measures, my preference will be for a measure
13 that is more comprehensive than less
14 comprehensive. My measure will -- my
15 preference will also be for measures which
16 explicitly delineate the key resource
17 categories, rather than having complete
18 lumping in what is being reported.
19 Those are my preferences. Given
20 that I'm going to be evaluated in that way, I
21 guess they should be explicitly in the
22 criteria.

1 CO-CHAIR LOTZ: Right.
2 CO-CHAIR STEINWALD: Barbara and
3 then Tom.
4 DR. RUDOLPH: Yes. There is sort
5 of another piece of this that we aren't
6 addressing, but I think that it may be
7 something that also needs a little bit of
8 modification, that's the submission form.
9 Oh, okay, we're going to get there
10 next, because as a sort of quasi-measure
11 developer, my experience was that I had a
12 really hard time knowing where to put things.
13 And then you have people looking for them in
14 certain places, not finding it there, thinking
15 you haven't said it and it's a mess.
16 CO-CHAIR STEINWALD: Tom and then
17 Lisa.
18 DR. ROSENTHAL: Yes. Maybe a
19 small friendly amendment to Jack's language
20 would be to add the term to the extent
21 possible, because while it would be lovely to
22 have the rehab and the SNF and the this and

1 the that, it is often impossible to get. But
2 it is desirable, so maybe just add the term to
3 the extent possible.
4 CO-CHAIR STEINWALD: Okay. Lisa?
5 MS. GRABERT: Yes. I would just
6 add on to that that we might want to go as far
7 as to say preference will be given to those
8 measures that address the full continuum of
9 care or services versus those that focus on
10 just discrete service categories.
11 MS. TURBYVILLE: Just a question.
12 I think it's very good input, but it sounds
13 like importance, because, at this point, we
14 have taken the measure as they have submitted.
15 They have said this is what we are submitting.
16 And then the scientific acceptability
17 component of the criteria is, okay, you have
18 submitted this measure.
19 Now, we are going to look at what
20 you submitted and see if it is reliable and
21 valid. And in addition, can you specify this
22 measure, which includes class of drugs, type

1 of drugs, diagnoses codes, everything that
2 someone would need in order to implement it
3 within and across the organization.
4 So that may vary a little bit for
5 the proprietary, you know, where we may ask
6 them to describe it, but that's my
7 understanding of the specification. It's the
8 recipe, yes.
9 DR. BURSTIN: Well, I think we can
10 figure out where that should live, but I think
11 that concept is important. I also don't want
12 to lose the second half of what Jack said.
13 You want a comprehensive, but you also want to
14 be able to have it transparent enough that you
15 can then dissect it, is part of what I thought
16 you were saying as well, Jack.
17 DR. NEEDLEMAN: Well, yes.
18 Implicit in use.
19 DR. BURSTIN: Right.
20 DR. NEEDLEMAN: As I can imagine
21 use is I need to know where I'm --
22 DR. BURSTIN: Yes.

1 DR. NEEDLEMAN: -- spending the
2 money, not just how much I'm spending.
3 DR. BURSTIN: Right. And just two
4 things I wanted to bring in, if I could, from
5 the measurement framework report. I think we
6 are also trying to, it sounds like, sort of
7 get at some of their guiding principles
8 overall, which is, part of what they were
9 saying is that measures used to inform
10 judgments, and it says, broadly on efficiency
11 should promote shared accountability across
12 providers.
13 I think that is kind of getting at
14 that notion of comprehensiveness, as well as
15 a second one that indicated that measures used
16 to inform judgements on efficiency should
17 respond to the need to harmonize measures
18 across settings.
19 So ensuring you get settings and
20 harmonization across them, I think, is
21 important as well. If, ultimately, the angle
22 is trying to get measures of an episode, you

1 have got to be able to capture the data across
2 different sites.
3 CO-CHAIR STEINWALD: All right.
4 Now, as I understand where we are, there is
5 still an issue of whether the content that we
6 have been discussing, that Jack advanced and
7 others added to, needs to be reflected. Is it
8 part of scientific acceptability or not? And
9 you suggested that you will figure out where
10 to put it in.
11 If everyone is content with that,
12 let's move on to 2B.
13 MS. TURBYVILLE: It would be
14 helpful, I think, even starting at 2A, to look
15 at the list and see if there are steps,
16 especially the ones that we have talked about.
17 Attribution, is that part of implementation
18 and not part of the specification that will be
19 evaluated or is it going to be evaluated and
20 held to validity and reliability type of test?
21 Peer group comparisons. Is that
22 part of implementation or is that actually

1 part of the measure specification?
2 CO-CHAIR STEINWALD: Thanks. I'm
3 not a measure developer and unlikely that will
4 ever happen, but others in the room have been.
5 You know, I guess, if I was
6 confronted with a list like this and told you
7 need to address every one of these items in
8 great detail, I might be discouraged from
9 developing or submitting a measure.
10 If you were to say if this were
11 intended to be a tool or a helpful tool that
12 says all of these things that are relevant to
13 the measure that you are developing ought to
14 be addressed or here are the kinds of things
15 that we believe are often relevant to measures
16 and should be addressed if your measure -- if
17 the item is relevant to your measure, would,
18 I think, be a little bit less uninviting to a
19 developer.
20 But as I say, I'm not a developer,
21 so I would be interested to hear some
22 comments. Paul and then David. Paul, then

1 Ethan and then David.
2 DR. BARNETT: So I guess I don't--
3 I appreciate what you are saying about not
4 wanting to make the criteria so extensive that
5 no one is going to submit a measure.
6 But I also anticipate that without
7 having each of these points addressed in a
8 systematic way, it is going to be impossible
9 to make a choice.
10 CO-CHAIR STEINWALD: Yes.
11 DR. BARNETT: And that we really
12 do need to have all this level of detail in
13 order to do the evaluation. And what strikes
14 me is that in looking at the list, 2A through
15 2M, and this other list which is all of the
16 different things that we would like to see is
17 that it's all here and it just needs to be
18 woven together.
19 And that a lot of the -- the one
20 list that's very comprehensive, I think, is a
21 great statement of what it is we need, and
22 what I would like to do is, but I don't think

1 we should do it as a Committee, realize that
2 some of these things are already dealt with in
3 2A through 2M. And there are a few that are
4 not and that need to be -- those need to be
5 expanded on and put in the two criteria.
6 And I'm not sure it's very
7 efficient use of the Committee's time to
8 figure it out right now doing it that way.
9 But what I'm struck with is that they are both
10 great documents and they just need to be
11 combined.
12 CO-CHAIR STEINWALD: Okay. Ethan?
13 DR. HALM: Yes. I mean, to
14 follow-up on that, I think, you know, there is
15 a lot of thoughtful explication yesterday that
16 has come up with this really nice set of steps
17 and so, you know, whether or not, you know, we
18 can appendicize that and, you know, we can say
19 that there is -- you know, here are the steps
20 that will be useful in, you know, evaluating
21 these things and sort of referencing it
22 elsewhere, we are not going to want to have,

1 you know, 2A through ZZ where we have, you
2 know, a sub-bullet for each of these.
3 And then people can look at that
4 and I assume from the evaluation perspective,
5 because the NQF takes this not -- all or
6 nothing approach, that not all these are must
7 haves, that would be okay.
8 It is hard to imagine us looking
9 at this list and getting, you know, 20 some
10 odd people to say all right, that's a must
11 have, that's a would be nice, that is, you
12 know, unlikely.
13 I think it is all going to be in
14 the eye of the evaluator and we can just -- if
15 there is a way to reference within the
16 document, that list, but not have to bullet
17 everything out, it would be useful.
18 CO-CHAIR STEINWALD: David and
19 then Bill.
20 DR. REDFEARN: I agree with Paul.
21 I think these things have to be in there. And
22 the developer has to address every single one

1 of these. Telling you -- I can say that
2 having done this myself in California for a
3 network development, I addressed every single
4 one of these things. I don't always have a
5 great solution, but I address every one of
6 them.
7 And when I see the developer
8 submit their proposals, I want to see an
9 intelligent response, intelligent comment
10 about every one of those and that will largely
11 be how I characterize the credibility of what
12 is being proposed.
13 I mean, I want people to make
14 intelligent comments about these issues,
15 because these are really hard issues and it
16 gives you a good sense about whether the
17 developer knows what is going on. These are
18 absolutely essential.
19 CO-CHAIR STEINWALD: Okay. Bill?
20 DR. GOLDEN: A brief comment. One
21 in response to David and Paul, I think we
22 could make a statement saying stronger

1 measures will address more of these measures
2 than less or something along those lines,
3 rather than making them absolutes.
4 Two, I would like to request on
5 the fourth bullet, if we have to discuss these
6 bullets, if these bullets are up for
7 discussion, to change that fourth bullet to
8 say define populations and in parentheses
9 would be patients and providers, because it
10 makes a difference whether you are, again,
11 going back to the systems issue, whether you
12 are going after individual docs or you're
13 going after facilities. So it would be nice
14 to have that defined in the program.
15 And three, near the bottom it has
16 -- you have an item that says attribution of
17 results. I think it should be attribution of
18 costs.
19 CO-CHAIR STEINWALD: Lisa and then
20 Barbara.
21 MS. GRABERT: I do like all of
22 these criteria. And I think the more criteria

1 that you have addressed in your measure
2 preference may be given to you as a developer.
3 I think that it is unrealistic to expect that
4 everyone has done every single one of these.
5 I would really like to see an endorsed
6 resource use measure, so I don't think that we
7 can make these absolute criteria.
8 CO-CHAIR STEINWALD: Okay.
9 Barbara?
10 DR. RUDOLPH: My comment relates
11 to 2B and 2C and this list. I think as they
12 are stated now, they are testing the
13 reliability of the results, not each of the
14 individual components.
15 And I could see where, at some
16 point, individuals on TAPs or whatever might
17 want sort of reliability testing for the
18 different hierarchies or for the peer group
19 selection or for the attribution of results.
20 And I think we need to be clear which items on
21 here are going to be, you know, required to
22 have more testing, such as reliability testing

1 or validity testing on the independent sort of
2 pieces of the construct.
3 CO-CHAIR STEINWALD: You have kind
4 of moved us a little bit. As I look at B and
5 C, they look like -- well, most of them are
6 standard statements of reliability and
7 validity. And if we agree that the measure
8 should meet both the reliability and the
9 validity test, then I think it makes sense to
10 have them identified as separate elements.
11 I don't know about the specific
12 verbiage, but, you know, maybe others have
13 ideas about that. If you are happy to address
14 B and C with the understanding that we haven't
15 resolved this list issue yet, why don't we go
16 ahead and do that. Maybe we can dispense with
17 it. Jack and then Paul.
18 MR. BOWHAN: To the point about
19 the specification of analytic steps, I think
20 and I agree with Paul that, maybe we can slice
21 and dice some of these and decide what we are
22 going to keep. I think there has got to be a

1 core that are absolute.

2 And if we don't have some of

3 those, I think this language that we have had

4 throughout that we have to be totally

5 transparent and be able to decompose. If you

6 are not going to require some real specifics

7 that get down to the real detail, you can't do

8 that.

9 So either you have to change that

10 wording or you have to keep some of the

11 specifics.

12 CO-CHAIR STEINWALD: Paul?

13 DR. BARNETT: So the reason why I

14 suggested making a very structured submission,

15 and I think it's brilliant on the part of the

16 way that NQF has set it up, is otherwise we

17 are going to be looking at a document and

18 saying, gee, did they deal with peer group

19 selection anywhere? We have to hunt through

20 a long text to try to find that one in

21 Submission A and then we have to do the same

22 thing on Submission B and Submission C.

1 And it is going to be an
2 insurmountable amount of work for us.
3 Whereas, if we say up front tell us this and
4 this structured place, it's just going to be
5 much simpler.
6 If we are going to put it all in
7 one big grab bag, I don't think we should
8 include those. If the problem is it's too
9 burdensome, then make the list shorter. But
10 don't create a grab bag category, because it's
11 just going to be too hard to evaluate.
12 It's like an open-ended question
13 in a survey.
14 CO-CHAIR STEINWALD: Yes. Helen,
15 did you want to say something?
16 DR. BURSTIN: Yes. I was just
17 going to suggest it might be helpful, actually
18 I don't know if we want to do this today or
19 whether maybe perhaps a small group wants to
20 engage in this activity, to take this long
21 list under the Resource Use Specifications and
22 make at least an initial strawman of what is

1 an absolute requirement for a submission and
2 what would be nice. It might get you sort of
3 a little bump up in your score, but not an
4 absolute requirement.
5 And then also, following up on
6 Paul's exercise of indicating also which of
7 them fit where in the -- somewhere in the very
8 sub-criterion 2. I think it would be easier,
9 for example, to know exactly where it is on
10 the submission form. He is absolutely right.
11 CO-CHAIR STEINWALD: Okay. We
12 have reached the time of public comment. Why
13 don't we turn to that? And then turn back to
14 the criteria.
15 MS. TURBYVILLE: Operator, could
16 you, please, open the line to see if any of
17 the audience have a comment or question for
18 the Steering Committee?
19 OPERATOR: If you would like to
20 ask a question or make a comment, you may
21 press Star 1 at this time on your telephone
22 keypad. It appears we have no comments or

1 questions, at this time.

2 MS. TURBYVILLE: Thank you.

3 CO-CHAIR STEINWALD: Where are we

4 in our timing?

5 MS. TURBYVILLE: It is almost

6 12:00.

7 CO-CHAIR LOTZ: Lunch would be next

8 or do you want to close this out? Do we have

9 volunteers for --

10 CO-CHAIR STEINWALD: Yes. Let's

11 close out the issue of how we are going to

12 address this list. Understanding that we are

13 not going to resolve all the questions that

14 were raised.

15 Should we make that the job of the

16 Subcommittee, because there is one?

17 MS. TURBYVILLE: Any willing

18 volunteers?

19 CO-CHAIR STEINWALD: Would anyone

20 like to volunteer to be on a Subcommittee to

21 address the -- all right. Bill Rich.

22 MS. TURBYVILLE: Lisa.

1 CO-CHAIR LOTZ: Lisa.
2 MS. TURBYVILLE: Paul.
3 CO-CHAIR STEINWALD: Okay. Good.
4 MS. TURBYVILLE: I would encourage
5 those of you who had strong --
6 DR. ELWARD: I would be glad to
7 help with that.
8 CO-CHAIR LOTZ: Did you say
9 something, Kurtis?
10 DR. ELWARD: I would be glad to
11 help with that, also.
12 CO-CHAIR LOTZ: Thank you.
13 MS. TURBYVILLE: I think those of
14 you who had stronger polarizing opinions, both
15 all inclusive and not all inclusive, should
16 find themselves on this work group, so that
17 you can represent both sides. Oh, Jack.
18 CO-CHAIR LOTZ: You've got strong
19 opinions.
20 DR. NEEDLEMAN: All right.
21 CO-CHAIR STEINWALD: I have Bill
22 Rich, Lisa, Paul, Kurtis, Dolores and Jack.

1 MS. TURBYVILLE: Excellent.
2 CO-CHAIR STEINWALD: All right.
3 Good. Okay. We will need to return starting
4 at 2B, but it is now time to break for lunch.
5 It is noon. What time do we need to reconvene?
6 MS. TURBYVILLE: We said half an
7 hour.
8 CO-CHAIR LOTZ: I think we took
9 about half an hour.
10 CO-CHAIR STEINWALD: Half an hour.
11 Okay. 12:30.
12 MS. TURBYVILLE: Kurtis, we will
13 reconvene at 12:30. We're going to break for
14 lunch.
15 DR. ELWARD: I probably will not
16 be able to rejoin you this afternoon, but if
17 I can, I'll call in.
18 MS. TURBYVILLE: Okay. Great.
19 And you know how to call in.
20 (Whereupon, at 12:00 p.m. the
21 above-entitled matter went off the record and
22 resumed at 12:38 p.m. the same day.)

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

2 12:38 p.m.

3 MS. WILBON: I want to start by

4 saying thank you to the volunteers. We're

5 going to call it probably the Resource Use

6 Specification Subcommittee or something like

7 that. We've got Bill Rich, Lisa, Paul,

8 Kurtis, Dolores and Jack.

9 CO-CHAIR LOTZ: And Kurtis.

10 MS. WILBON: Yes, he's on there.

11 Any others? That's a pretty good size. So we

12 will be -- NQF will staff that and so we will

13 be emailing all of you in the next couple of

14 days in helping find a time on the phone that

15 works for everybody and get you the materials

16 that you need to move this forward, so you can

17 make a recommendation back to the Steering

18 Committee.

19 So if there are any questions

20 about that, perhaps we could take them now.

21 Yes?

22 DR. BARNETT: One thing that would

1 be helpful is to have a crosswalk between
2 those two documents that we are trying to
3 reconcile.
4 MS. WILBON: Okay.
5 MS. TURBYVILLE: All right. Thank
6 you.
7 CO-CHAIR LOTZ: Okay. Bruce and I
8 have a difference of opinion of where we are
9 at. I think we are done. No. I'm sorry, I
10 missed what Paul just said.
11 CO-CHAIR STEINWALD: He said 3.
12 CO-CHAIR LOTZ: That's where I
13 think we are at.
14 MS. TURBYVILLE: Yes.
15 DR. BARNETT: Weren't we at 2B?
16 CO-CHAIR LOTZ: That's where Bruce
17 thinks we are at. That's where I think we are
18 at. All right. Let's start again on the same
19 page.
20 We have put together the
21 Subcommittee of folks that hopefully are
22 engaged and hopefully bring some different

1 opinions and some expertise specifically
2 around the scientific -- the measurement of
3 scientific appropriateness.
4 CO-CHAIR STEINWALD:
5 Acceptability.
6 CO-CHAIR LOTZ: Acceptability,
7 pardon me. And I would suggest that they look
8 at the additional measures that were put on
9 the Word document that we have come to over
10 the last couple of conversations in the last
11 day and a half as well as A through, whatever.
12 CO-CHAIR STEINWALD: M.
13 CO-CHAIR LOTZ: M. And comment
14 broadly there. And then we should begin our
15 conversation at 3, which is usability. Is
16 there anyone who feels uncomfortable with that
17 strategy? Again, the broader Steering
18 Committee will be asked and, please, do
19 comment on No. 2 when we see that come back
20 from the work group.
21 Even if you are just fine with it,
22 I know having occasionally been in the

1 position where I had to weave together all the
2 comments, you never know if people aren't
3 commenting because they are on holiday for a
4 week and a half and haven't seen the email or
5 whether they are fine with what is written.
6 So Sally hasn't asked for it, but
7 I think in general as a courtesy to the author
8 and, you know, the person who has to bring all
9 of these various different opinions together,
10 if you could just say I'm fine with it, that
11 would be great as well. At least that way we
12 know that you saw it. You can certainly
13 change your mind later on.
14 Then hearing no dissent, let's go
15 ahead with 3, which is to discuss the
16 usability.
17 MS. TURBYVILLE: Just I do want to
18 -- and I'm fine with this approach. The
19 comments before that we said we would not
20 forget, which include the costing method,
21 etcetera, right now, the way it is placed, it
22 would be in this scientific acceptability that

1 the Subcommittee is going to work.
2 I just wanted to make that clear.
3 That's where it is currently housed. So if it
4 needs to be housed elsewhere, you can bring it
5 up at the time. But I guess the Subcommittee
6 will focus on that quite intently and come
7 back to the work group, the Steering
8 Committee.
9 CO-CHAIR LOTZ: So maybe a half an
10 eye toward the Word document of the analytic
11 steps and if you think an analytic step
12 belongs in 3 or 4, for our next hour and a
13 half or so of discussion, then, you know, say
14 it now.
15 All right. Looking at usability.
16 The first row talks about some general
17 statements. We have added a statement that
18 reflects a lot of our conversation about
19 putting resource use measure in the context of
20 quality. Comments on the general statement?
21 Go ahead, Bruce.
22 CO-CHAIR STEINWALD: Yes. Well, I

1 thought that the term that brings resource use
2 and quality together is efficiency. I think
3 we should be consistent. And you know, we
4 have said that we don't think that resource
5 measures by themselves are as useful as they
6 could be when they are in combination with the
7 quality measures or when the measures
8 themselves are comprehensive enough to include
9 outcomes.
10 To say usefulness in the context
11 of quality, to me, isn't completely consistent
12 with our prior discussion, but I would be
13 interested in what others have to say.
14 CO-CHAIR LOTZ: Sure. Advocating
15 for more consistent wording from the first
16 half of the document to the second half of the
17 document. Barbara?
18 DR. RUDOLPH: I would agree with
19 your take on that, Bruce. We need to change
20 the working on that italics sentence to
21 something like resource use measures used in
22 combination with quality metrics, you know,

1 will, whatever, let's see, be understandable
2 to the intended audiences or something like
3 that.
4 CO-CHAIR STEINWALD: She is in
5 charge.
6 CO-CHAIR LOTZ: Oh, sorry. Tom?
7 DR. ROSENTHAL: Yes, I agree about
8 trying to make it consistent. One of the
9 challenges about sort of the quality metrics
10 is that if you think about it, there is only
11 X number defined quality measures that have
12 had the full scale of endorsement from the
13 NQF.
14 And if one figures that that is
15 the universe of proven quality measures, then
16 we would be limiting people tremendously by
17 the constraint of having a resource
18 measurement that only tracked to an extent
19 proven quality measurement.
20 But maybe we could get the idea of
21 in the absence of a proven one, even putting
22 in your submission how one might go about

1 developing the quality measure that would
2 correspond to the cost metric.
3 And again, we used the example
4 yesterday of VADs or of hip replacement,
5 again, I could see hip replacement being a
6 very interesting thing to understand the cost
7 of and it would be pretty apparent what the
8 quality outcomes would need to get developed,
9 but they don't have any national imprimatur of
10 acceptability, but they could if the cost
11 measurement came into being.
12 So I just wonder and I don't know
13 what the wording would be that would
14 incorporate the notion that there are only a
15 small number of really proven quality
16 measures, but that if you came up with a very
17 important cost measure, if you were to
18 indicate the way in which one would go about
19 measuring quality in the future, that that
20 would be an acceptable addition.
21 MS. TURBYVILLE: And, Helen, maybe
22 you can add to this or tell me if I've got it

1 wrong. We did talk about this context of
2 quality and how far to push it and how far --
3 and decided that we wanted to focus on
4 resource use measures. And it sounds like the
5 Steering Committee is in agreement with that.
6 One idea that we had was to during
7 the submission process request that the
8 resource use measure submitter indicate
9 existing measures of quality that they know to
10 have been linked to these resource use
11 measures. That way in some ways we are
12 getting out of having to evaluate whether or
13 not that quality measure is good enough.
14 But it provides information to
15 users that oh, and this measure has been used
16 alongside this quality measure type. And so
17 it would be informational. It would be framed
18 as informational.
19 So, Helen, I don't know if you had
20 anything to add to that?
21 DR. BURSTIN: I'm sorry. I missed
22 a bit of this. I actually think in some ways

1 these resource use measures could stand alone
2 in terms of usefulness, particularly at
3 purchasers and others. I mean, just having
4 the information is a lot more useful than not
5 having it.
6 And, you know, if anything, I
7 would say perhaps just something really
8 simple. I can understand the results of the
9 resource use measures and likely to find them
10 useful for decision making, you know,
11 especially when coupled with quality measures.
12 Just leave it vague. Just say,
13 you know, keep it simple.
14 CO-CHAIR LOTZ: We had previously
15 said that we would value them, rate them
16 higher when they were coupled with quality
17 measures. Are we backing away from that? And
18 then a second thought for consideration is do
19 they have to use NQF-endorsed quality
20 measures, if they exist? Isn't that a bit
21 self-serving? Yes, Bill?
22 DR. GOLDEN: Yes. I think that

1 the bolded sentence is a little vague or it
2 may be confusing, especially since we are
3 asking for building blocks. So I would maybe
4 suggest something along the lines of potential
5 utility of measure in assessing outcomes or
6 something like that.
7 I'm not sure we want to
8 necessarily talk about quality, since that can
9 be process or outcomes. We really want to
10 talk about cost versus outcomes here. But to
11 assess this measure, we really want it in how
12 useful it will be in evaluating a particular
13 outcome.
14 MS. TURBYVILLE: Were you on 3A?
15 I'm sorry.
16 DR. GOLDEN: Yes.
17 MS. TURBYVILLE: Okay. Thank you.
18 DR. GOLDEN: I thought that's
19 where we -- what are we on now? Are we on 3A?
20 MS. TURBYVILLE: We're on the
21 intro.
22 DR. GOLDEN: The intro? Well, I

1 was looking at the slide up there, so -- no,
2 I was on the intro. I'm sorry.
3 CO-CHAIR LOTZ: Yes, that's what I
4 thought.
5 DR. GOLDEN: I was on the intro.
6 CO-CHAIR LOTZ: Yes, so instead of
7 specifically saying the context of quality,
8 saying it, you know, in the --
9 DR. GOLDEN: You can either --
10 eliminate usefulness of resource of the
11 resource measure in the context of outcomes,
12 of an outcome.
13 DR. BURSTIN: Because you may find
14 the building block useful in the context of
15 decision making in and of itself.
16 CO-CHAIR STEINWALD: I'm fine with
17 that.
18 CO-CHAIR LOTZ: Bill, did you want
19 to continue your comments or you are okay?
20 DR. GOLDEN: No. I'm just
21 catching up with myself here.
22 CO-CHAIR LOTZ: 3A, here we have

1 again the idea of perspective. I think that
2 since we have four broad sections here, it is
3 reasonable to reiterate the need for a measure
4 developer to comment on the perspective that
5 they are seeing this from.
6 So this may seem a little
7 redundant, but we want some redundancy when it
8 suits a purpose. David?
9 DR. REDFEARN: I would just take
10 out, e.g., focus group cognitive testing,
11 because those don't seem like examples of
12 public reporting to me.
13 CO-CHAIR LOTZ: Steve?
14 MR. PHILLIPS: I would just offer
15 instead of or cost containment strategies,
16 maybe or measuring resource utilization. I
17 guess just as, you know, the cost containment
18 strategies, especially or separated from
19 quality measures, just raises some concerns,
20 you know, that you are now using these in
21 terms of reducing costs or strategies to
22 reduce cost without having any linked outcome

1 measure.

2 So maybe a little more neutral

3 would be just, you know, measuring the

4 resource utilization.

5 CO-CHAIR LOTZ: Go ahead, Helen.

6 DR. BURSTIN: Actually, to make an

7 observation that I think, in general,

8 usability kind of works. And I would just

9 leave it be unless anybody feels strongly that

10 it -- I mean, I'm not sure there is anything

11 distinctly different about usability for

12 resource use measure versus another kind of

13 measure.

14 And really very simply, can the

15 intended audiences use it for better decision

16 making? Is it useful information? I'm not

17 sure you need to do a whole lot of

18 wordsmithing here and I would just kind of

19 clean it up.

20 CO-CHAIR LOTZ: Use your mics,

21 please.

22 DR. BURSTIN: Yes, yes. I mean,

1 not adding -- you can go to 3D or 3E. I mean,
2 again, those can just be explanatory for the
3 actual developer. But I'm not sure you are
4 actually fundamentally changing the criteria
5 or the sub-criteria here. You are just kind
6 of adding explanatory verbiage and I don't
7 know.
8 CO-CHAIR LOTZ: Ethan?
9 DR. HALM: The only difference is
10 the quality improvement stuff may not
11 necessarily --
12 CO-CHAIR LOTZ: Right.
13 DR. HALM: -- be the only purpose
14 the resource uses would be useful.
15 DR. BURSTIN: I think some people
16 consider having cost information part of your
17 QI activities, so --
18 CO-CHAIR LOTZ: But I think Ethan
19 was saying not limiting it to just quality
20 improvement. Bill Golden?
21 DR. GOLDEN: What I was just going
22 to say, I was going to suggest the term

1 clinical effectiveness and get rid of the rest
2 of the material. But in this item, are we
3 really stressing the requirement for public
4 reporting? I'm not sure we are going to be
5 publicly reporting these cost resource items.
6 This is a building block.
7 CO-CHAIR LOTZ: Yes.
8 DR. GOLDEN: So is that a relevant
9 item or is that a limiting item?
10 CO-CHAIR LOTZ: I don't know.
11 DR. GOLDEN: Because the way it
12 reads, it almost looks like that is a
13 requirement that it needs to be intended for
14 public reporting.
15 CO-CHAIR LOTZ: Let me marinate
16 that for a second. Hang on, Janet is going to
17 weigh in.
18 MS. CORRIGAN: I think you are
19 actually raising a very good point. This is
20 a recent change that was made at NQF. Our
21 Board, essentially, affirmed that the purpose
22 of measures is for both public reporting and

1 for quality improvement. But it may well be
2 that you have some types of measures that are
3 building blocks of other measures that
4 ultimately get publicly reported. And that
5 probably will be something to consider very
6 carefully.
7 CO-CHAIR LOTZ: Yes. Dolores?
8 MS. YANAGIHARA: I think the other
9 thing to consider is the level of scrutiny
10 that comes along with public reporting. So
11 you need to make sure that that measure is
12 going to stand the test of being ready for
13 public reporting. Whether or not it actually
14 is or not is a different story.
15 So I know that there is a lot of
16 political issues and whatever around public
17 reporting, but I think the measure needs to be
18 ready for public reporting. And that's, I
19 think, what this is getting to, but it has to
20 be scientifically acceptable and, you know,
21 meet all those criterion and meet that level
22 of scrutiny.

1 So something that is different
2 than what you need for quality improvement
3 versus what you need for public reporting.
4 CO-CHAIR STEINWALD: I would be
5 interested to know what the people who are
6 familiar with measure development think. If
7 public reporting were seen to be a requirement
8 of the measure, a required use of the measure,
9 potential use, could that be a deal breaker
10 for measure developers?
11 I mean, this is part of the theme
12 of not wanting to discourage development,
13 submission of measures.
14 CO-CHAIR LOTZ: Barbara?
15 DR. RUDOLPH: Well, I'm just
16 speaking from more of the purchasers'
17 perspective on this one. I think we don't
18 want to go through the extreme effort it takes
19 to get a measure endorsed and have it be used
20 just for quality improvement.
21 We participate in NQF because we
22 believe in public reporting. And we want

1 public -- measures that are available for
2 public reporting.
3 Now, sometimes they can be paired
4 with something else, a requirement might be a
5 pairing like you have readmission paired with
6 length of stay, something like that, but I
7 think I wouldn't want to spend all my time on
8 this Committee if I thought that this measure
9 was never going to be publicly reported or not
10 available for public reporting.
11 CO-CHAIR LOTZ: Jeptha?
12 DR. CURTIS: I appreciate that,
13 but I have a slightly different take on it.
14 And I do think that the stakes are so much
15 higher when you are setting something up for
16 public reporting, that the scrutiny and the
17 emotional level of the process is much higher,
18 that I wonder if we would be setting ourselves
19 up to have no measures that have any broader
20 public support to them.
21 So for instance, I was thinking in
22 my head what would it look like if they had

1 classifications by physicians, but then they
2 misclassified those zebras that David was
3 talking about yesterday, those physicians who
4 are acting outside their certification or
5 their training.
6 And what would be the possible hue
7 and cry if that were to happen on any sort of
8 regular basis? And we know that no measure is
9 perfect, but at the same time, that might
10 break down the whole process as you go
11 forward.
12 So I think that the goal should be
13 for public reporting if possible, but I don't
14 know if it should be a requirement therein.
15 CO-CHAIR LOTZ: David?
16 DR. PENSON: I have to say I kind
17 of fall on Barbara's side with this. And I do
18 think that ultimately the goal here whether it
19 is a quality measure, whether it is a resource
20 use measure has to be about public reporting
21 and yes, there are going to be some
22 methodologic issues and we have to think about

1 risk adjustment.
2 But the fact of the matter is, if
3 one of the goals here, unstated or otherwise,
4 is to reduce utilization and maybe have more
5 consumer-driven health care, I kind of think
6 that's a bar we want to set. If we set the
7 bar too low, we're going to end up with
8 garbage.
9 CO-CHAIR LOTZ: Mary Kay?
10 DR. O'NEILL: If the unit of
11 reporting is the performance of an individual
12 physician, this issue has been encountered
13 across the country already and there has been
14 formalized agreement that was driven by the
15 New York Attorney General that has been agreed
16 upon about the process of reporting on
17 physician performance and appeals process and
18 notification and things like that.
19 So that's already standard across
20 the country. And maybe we need to say that we
21 would follow that same set of regulations, but
22 it allows for public reporting and it allows

1 for feedback and correction of errors in the
2 reporting processes.
3 DR. CURTIS: If I could just jump
4 in on that then? I guess my -- and I agree
5 that that's good. It definitely is feasible
6 and it is hard. You're going to get that
7 pushback, we know all these things, but it's
8 still doable.
9 I'm worried that this is at an
10 earlier stage in the process, that the science
11 isn't as fully developed, that, you know,
12 there is going to have to be evolution of
13 these measures over time to the point where
14 you would have that expectation that they are
15 all public reporting.
16 I just don't know if it's where we
17 want to be, at this stage. But, you know, I
18 think somewhat relatedly, I don't know if we
19 can push those forward. If we are going to be
20 in a position where we can push this forward
21 and I just have a feeling that it will be --
22 it is the third rail. We have talked about it

1 before, but it may be difficult.
2 And in reality, who are the
3 consumers of this information going to be? We
4 have talked about and the white paper mentions
5 that, you know, patients are going to choose
6 their provider on the basis of resource use
7 and/or quality.
8 I think that's a pie in the sky.
9 I do not think that any consumer is going to
10 go there and say I'm going to choose this on
11 the basis that they are efficient or that they
12 have low resource use.
13 I would speak for myself, as I
14 would probably choose the guy who is willing
15 to use the most resources on my behalf. You
16 know, the audience for this, the public,
17 quote/unquote, is not the patient. It is the
18 payor. It is the consumer group. It is other
19 people than the patient.
20 And so I think it's a different
21 public than what we have traditionally thought
22 of for NQF measures.

1 CO-CHAIR LOTZ: Jeff Rich?
2 DR. JEFFREY RICH: Yes. I have to
3 say, having been on the Board at NQF and been
4 in this conversation with Barbara and Janet
5 about measures for quality improvement,
6 measures for public reporting, it was always
7 an interesting conversation.
8 Then having gone to CMS and
9 realizing the pressures and intentions that
10 exist there, I can't see how we would develop
11 measures that we wouldn't publicly report.
12 The train has really left the station on
13 public reporting on both resource use and
14 quality.
15 The PQRI is going to be publicly
16 reported and CMS is developing a group and
17 they are going to publicly report. So I can't
18 see us not sort of requiring or asking very
19 strongly that these measures be ready for
20 public reporting.
21 CO-CHAIR LOTZ: Lisa?
22 MS. GRABERT: Some of the feedback

1 that I have heard from hospitals as it
2 pertains to episodes of care are that
3 hospitals really do understand what happens
4 inside their four walls, but outside of their
5 four walls, they have no idea what is
6 happening to their patients.
7 And to the extent that these
8 episodes can provide more information publicly
9 to hospitals across the continuum of care, I
10 think it would be easier to manage patients
11 and become more accountable.
12 So I think generally, hospitals
13 are in favor of publicly reporting resource
14 use measures across the continuum of care.
15 CO-CHAIR LOTZ: Bill Golden?
16 DR. GOLDEN: Yes, I'm just
17 following the comments earlier that it may be
18 too early in the game and that we will invite
19 scrutiny. Too much scrutiny at this stage
20 could end up hurting future innovation.
21 And if we are creating resource
22 measures for public reporting, because we

1 can't come up with efficiency measures, and
2 we're just calling them something different
3 and stripping out the quality measures, have
4 we accomplished something?
5 So, you know, just listing an
6 unadorned resource measure without any context
7 of outcomes, you know, is that progress? I'm
8 not sure. And are we better off finally
9 seeing what we get and encouraging innovation
10 before we commit ourselves to all the measures
11 need to be publicly reported?
12 CO-CHAIR LOTZ: Ethan?
13 DR. HALM: Yes. I would be in
14 favor of being less absolute about the public
15 reporting piece. That, you know, would be
16 optimal, that's the goal. I don't know
17 whether or not, you know, a measure would want
18 to flunk out on this.
19 I'm thinking of the attribution
20 problem we discussed yesterday, in that we
21 talked about that plans, delivery systems,
22 accountable care organizations might, in fact,

1 you know, want to use this information
2 internally for improving care. But the
3 measure at the physician level, at the
4 provider level might not be something where it
5 is useful or you need to report on that
6 publicly.
7 Maybe reporting at the higher
8 group of plan level. And, you know, Tom Lee
9 is not here today, but he was talking about
10 some of the things that his large organization
11 is trying to do with this. And I just worry
12 about being absolutist with that. If you are
13 not going to say the word public reporting for
14 this, then NQF is not going to comment on
15 whether or not the measure otherwise is valid,
16 reliable, stable or useful.
17 CO-CHAIR LOTZ: I'm going to let
18 Helen jump in, because she has to go soon.
19 DR. BURSTIN: Before I have to
20 leave, I just want to make one clarification.
21 The way this is written is the measures are
22 intended for public reporting. The actual

1 requirement that the measures are publicly
2 reported is actually something at maintenance,
3 which is within three years.
4 So you are not exactly -- we ask
5 the measure developers up front to indicate if
6 there is a plan of how the measures would be
7 publicly reported, but we recognize there is
8 a continuum of public reporting.
9 And initially, beyond initial, you
10 know, beyond the internal QI, which is not
11 NQF's game, you could do, you know, reporting
12 to CMS, reporting to health plans, reporting,
13 you know, until you get to the ultimate point
14 of reporting to the public at large.
15 So I don't think you need to spend
16 a whole lot of time, I think, on this issue,
17 recognizing the fact that this is a big issue
18 overall for all of NQF, not particularly
19 unique to resource measures, although I
20 recognize they are a lot more sensitive.
21 I think within three years, a lot
22 of this will shake out. It will be public

1 domain Grouper. I think there is a potential
2 for a lot of movement in this field over the
3 next three years.
4 CO-CHAIR LOTZ: Jack Needleman?
5 DR. NEEDLEMAN: Following on
6 Helen's comment. While I understand this is
7 a very sensitive issue and people have very
8 strong feelings about it, it is a -- from my
9 perspective as a consumer, which is a non-
10 clinician, it is a red herring.
11 You don't get reporting until
12 somebody has actually run the data and put it
13 somewhere. And at the moment, for these sets
14 of measures, we don't have any obvious folks
15 who are going to be running the data and
16 putting it somewhere.
17 To the extent that we do, it is
18 going to be folks that are doing -- that are
19 mediating the data. It's not going to be just
20 send it out to the consumer, you know. We
21 have already -- you know, there are plenty of
22 examples of how do we find the right doctor.

1 If you live in Washington, you've
2 got Washington Checkbook giving you consumer
3 ratings of doctors in Washington. In LA we've
4 got Angie's list giving you consumer ratings
5 of doctors. You go to New York magazine or
6 Washingtonian magazine, the areas best
7 doctors.
8 Well, you know, none of those are
9 terribly good sources of finding the areas
10 best doctors, but partly that is because
11 they've got nothing but reputation or surveys
12 to do.
13 So any of those organizations will
14 be mediating, you know, the data if it is made
15 available to them. So you've got the issue of
16 the data being made available. And then
17 somebody with some thought and reflection on
18 trying to make sense of what it says actually
19 putting it out.
20 So I just don't see -- you know,
21 the question is is that data -- is the measure
22 strong enough that it could be publicly used?

1 And I would argue that if it is good enough
2 for internal use at some abstract level, it's
3 good enough for external use. But the
4 external use is not going to get there any
5 time soon, because of the absence of vehicles
6 for actually generating the data and making it
7 available to the public at-large.
8 So as I said, for me, it's a red
9 herring issue.
10 CO-CHAIR LOTZ: Jack Bowhan?
11 MR. BOWHAN: Since this is the
12 building block for something that we think is
13 more important to efficiency, I don't know
14 that we want to even put out the risk of
15 reporting just resource use for what was
16 mentioned earlier today about, you know,
17 under-utilization.
18 Just because it is less doesn't
19 mean it is better. And so I don't know that
20 we want to talk about public reporting
21 resource measures. What we really want to get
22 to is maybe public reporting efficiency

1 measures. So I would not be in favor of
2 necessarily reporting resource measures.
3 But to Dolores' point, that we
4 write them in a way that would meet that kind
5 of strict criteria.
6 CO-CHAIR LOTZ: All right. Paul?
7 I was just about to say it looks like we are
8 done with this topic.
9 DR. BARNETT: It does. So I'm not
10 sure the practical impact of either including
11 or excluding it on our evaluations, but it's--
12 so I was just trying to think how would I
13 apply this criteria?
14 So if it actually was an
15 efficiency measure and included quality in it,
16 then it would be public -- it would be useful
17 for public reporting and we would rate it
18 higher.
19 If it is one of these other, you
20 know, building blocks and not useful for
21 public reporting, then this is not germane.
22 And so I think it should stay and I think it

1 actually is useful. Having this in here is
2 useful in terms of applying this to judge
3 measures.
4 CO-CHAIR LOTZ: Yes. By way of
5 again trying to provide some summary of the
6 discussion, what I'm hearing is that it
7 certainly should be presented with a fair
8 degree of rigor. We said that in a number of
9 other conversations, but there is no mandate
10 to publicly report it at this stage of the
11 game.
12 This is under the umbrella of, you
13 know, usability. So as I look at this
14 particular statement, I think is it useful for
15 public reporting? Well, that depends on the
16 perspective again. And having worn a few
17 hats, I can see where it would be useful, but
18 other people are presenting other perspectives
19 to say, you know, that's not so useful.
20 I also hear some issues that some
21 of the concerns seems to be around the, you
22 know, methodology and the accuracy. And I

1 think that comes in under our scientific
2 acceptability part as well.
3 So I would put out there as --
4 well, Bruce would like to say something and
5 I'll certainly, you know, invite him in to do
6 that. But it seems as though in sum, we leave
7 it alone and let some of these other aspects
8 that have been brought up get filtered out
9 when we are actually looking at a particular
10 measure, when we are considering it based on
11 the perspective that's being brought and as
12 Helen mentioned, it really becomes a more
13 compelling characteristic when we are looking
14 at, you know, reaffirmation of its importance.
15 Bruce?
16 CO-CHAIR STEINWALD: Yes. Looking
17 at the sentence and putting aside the
18 parenthetical expressions, isn't public
19 reporting for the purpose of improvement?
20 Part of my problem is it seems like these are
21 two separate things.
22 And, in fact, the one thing is

1 improvement, ultimately in efficiency. But I
2 don't see why public reporting is any more
3 distinct from other measures to achieve
4 improvement than any of the other things that
5 we have already discussed.
6 And I raised the issue initially
7 because it makes it seem like it is two
8 different things the way it is written,
9 informing improvement and efficiency in a way
10 we use resources or public reporting. And to
11 me, they are not different things.
12 Public reporting is for the
13 purpose of making improvements.
14 MS. TURBYVILLE: Can I comment on
15 that?
16 CO-CHAIR STEINWALD: Yes, sure.
17 MS. TURBYVILLE: So I think from,
18 you know, putting -- clearly, the NQF hat on
19 what the -- the reason why they are split out
20 is that the measure in its usability and
21 understandability would be tested through
22 focus groups, et cetera, showing or

1 demonstrating that people understand this
2 measure.
3 And I think that's why. So I
4 agree there is this idea that public reporting
5 will move the industry to improving, but I
6 don't think that this was what that was trying
7 to get at. So perhaps it is -- but it's, you
8 know, this understandable to the intended
9 audience, for example, through focus groups
10 and cognitive testing.
11 DR. GOLDEN: I want to follow up
12 on the comments. Public reporting -- I mean,
13 it was always Bruce and it was always
14 discussions about public reporting versus
15 quality improvement.
16 Public reporting was not primarily
17 for quality improvement, but was to inform
18 choice. So it's a different function. And
19 really that has been traditionally the primary
20 vehicle, the primary reason for public
21 reporting.
22 CO-CHAIR STEINWALD: But -- well,

1 all right. Then maybe this is a debate we
2 don't need to have now. Although, this fellow
3 who is referred to, Tom Lee, I read his book
4 and he makes it clear the statement that the
5 reason you have public reporting is not
6 because the public gives a damn or even reads
7 the reports --
8 DR. GOLDEN: Exactly.
9 CO-CHAIR STEINWALD: -- it is the
10 providers --
11 CO-CHAIR LOTZ: The people are
12 being reported.
13 CO-CHAIR STEINWALD: -- that will
14 respond.
15 DR. GOLDEN: Well --
16 CO-CHAIR LOTZ: Hang on, hang on.
17 DR. GOLDEN: Yes.
18 CO-CHAIR LOTZ: Hang on, guys. We
19 have some order here.
20 DR. GOLDEN: That's from 10 years
21 ago.
22 CO-CHAIR STEINWALD: Yes.

1 CO-CHAIR LOTZ: Jeptha?
2 DR. CURTIS: I just think that, I
3 mean, I'm comfortable with keeping it
4 certainly and I think it is set to the
5 standard that we want to meet that they could
6 be publicly reported. I just think that the
7 intent is the question.
8 And I think that another opt-out
9 might be to say not just that it's focus
10 groups or specified, because when I think
11 focus groups, I think patients sitting around
12 the room looking at numbers of which I don't
13 think these would be necessarily
14 interpretable, but maybe expand that
15 perspective to include other groups of
16 consumers. And I don't know what that would
17 look like, but maybe the physicians or others,
18 you know, a wider net for focus groups and
19 testability or testing.
20 CO-CHAIR LOTZ: Jack, I don't know
21 if you are still up or if you are -- Jack
22 Bowhan, are you --

1 MR. BOWHAN: It's just up.
2 CO-CHAIR LOTZ: I didn't think so.
3 Okay. Jeff Rich?
4 DR. JEFFREY RICH: I was just
5 reflecting on your comment, Bruce, and I think
6 it's right. When I was at CMS, there were
7 only two ways to modify behavior and that was
8 either to make results transparent and get
9 providers to react to that transparency or to
10 change their payments and get them to react to
11 that transparent -- to that.
12 So with the hospital required
13 conditions was probably the most brilliant
14 small issue -- I mean, small payment
15 adjustment that we ever made that created so
16 much behavior change and it was so important
17 for patient care.
18 And so when we went out with the
19 hospital compare and the nursing home compare,
20 we saw a lot of behavior changes on a basis of
21 transparency and it doesn't inform consumer
22 choice, but there is a lot on the behavior of

1 provider side, too.

2 DR. GOLDEN: This goes back to

3 2000/2001 when I was originally on the NQF

4 Board also and originally it was for choice.

5 And granted, the whole notion of quality

6 improvement by public humiliation which is

7 something I brought up a long time ago, is

8 still, you know, a valid driver of change.

9 But I think then it then sets a

10 higher bar for the measures you use. And so

11 that's fine. We can go that route, but then

12 don't be surprised if people get pickier about

13 going over these measures when they come in as

14 to what is selected and endorsed.

15 CO-CHAIR LOTZ: Bill Rich?

16 DR. WILLIAM RICH: You know, I

17 think public reporting, I agree completely

18 with Jeff and David. It is happening now.

19 And it is a strong driver for physician

20 behavior. We are going to see aberrations in

21 any of these new resource measures that come

22 through. They will be implemented for tiering

1 and there will be distortions that occur. But
2 I don't think you can anticipate or predict
3 that.
4 But the fact of the matter is
5 public reporting is part of the game and I say
6 we just leave it in and move on.
7 CO-CHAIR LOTZ: Barbara?
8 DR. RUDOLPH: Yes. My only
9 comment was these measures are going to be
10 given the very thorough review irrespective of
11 whether it was quality improvement or public
12 reporting.
13 Any of the measures that, you
14 know, really get to the kind of the heart of
15 the issue like this, resource use or whether
16 it was readmissions or mortality, the big
17 hitters are going to get reviewed very
18 thoroughly by all the TAPs, by the Steering
19 Committee, by the public comments, by all the
20 associations, by everyone. I mean, we can
21 expect a lot of input and a lot of activity.
22 CO-CHAIR LOTZ: Yes. Jeff Rich?

1 DR. JEFFREY RICH: And just
2 remember that we are on an accelerated time
3 line here. There is some expediency for
4 getting these measures. And so I think by
5 adding public reporting. and as, Bill, you
6 said, it's going to raise the bar. I think we
7 need to raise the bar quick and get really
8 good measures out there, because the most
9 violent reactions are when you change payments
10 based on these measures, not so much when you
11 make them transparent, but when you change
12 payment.
13 And payment is going to change on
14 the basis of these measures rather soon. In
15 the next three to five years. And so we need
16 to sort of prepare providers in order to give
17 them good tools that are reliable, that they
18 feel reliable and are ready for public
19 reporting, because it will happen.
20 CO-CHAIR LOTZ: So again, looking
21 for some place where we have a consensus or at
22 least minimal discomfort, we leave it alone.

1 Jeptha had mentioned broaden the examples of
2 who we get information from to include some
3 other types of consumers, not consumers, but
4 other types of users, so it doesn't look like
5 this is all just directed at consumers.
6 You were thinking about adding or
7 you had mentioned adding physicians or other
8 players.
9 DR. JEFFREY RICH: Clinicians.
10 CO-CHAIR LOTZ: Clinicians, right.
11 Thanks. I would say providers, but then
12 people think I'm talking about pharmacists, so
13 I don't know about that. Well, they are
14 providers, but it's not just them. Any --
15 MS. TURBYVILLE: I guess I just
16 want to put out and we will go back as staff
17 and take all this great input and then try and
18 give it back to all of you that if we get
19 super explicit on who it should be tested on,
20 then we want to be inclusive of that list.
21 Whereas, right now, maybe we add
22 some other examples of how you might test it,

1 but it doesn't say a focus group of a
2 particular population right now.
3 So maybe we will play with that
4 and see what else we could add to make sure it
5 is expansive and not misleading.
6 CO-CHAIR STEINWALD: Or you could
7 leave it out or leave the parenthetical
8 statement out.
9 CO-CHAIR LOTZ: Joe, you are
10 playing with your table tent.
11 DR. STEPHANSKY: The bar is going
12 to be raised immediately for many of us. I
13 know if NQF were to endorse a resource measure
14 that applied to hospitals without any
15 reference to quality, immediately, I would
16 expect the payers in our state to start
17 effecting our payments based on those kind of
18 measures immediately.
19 They would go right into pay for
20 performance programs, for example. So it's
21 not a matter of waiting around. It will
22 affect the employers right away. It is going

1 to hit the providers immediately and so we
2 might as well have it say ready for public
3 reporting right from the beginning.
4 CO-CHAIR LOTZ: Jeff Rich?
5 DR. JEFFREY RICH: Yes. 2012 for
6 hospitals. Remember, these are legislatively
7 mandated to use and in 2015 value modifiers
8 for physicians. Resource use measures and
9 quality measures applied against a physician
10 fee schedule called value modification by 2015
11 that begins. So that's not that far.
12 And, you know, if you are sitting
13 at CMS where I was, you are going to -- you
14 know, you have fulfill the requirements of the
15 law. So you are going to take what is out
16 there and start applying it to the physician
17 fee schedule.
18 CO-CHAIR LOTZ: Any -- oh, sorry.
19 MS. TURBYVILLE: Sorry. We have
20 someone on the line that is having a hard time
21 hearing, so let's remember to speak into the
22 microphone directly.

1 CO-CHAIR LOTZ: Any additional
2 comments?
3 MS. TURBYVILLE: I'm sorry, go
4 ahead.
5 CO-CHAIR LOTZ: On 3A? Oh, sorry.
6 All right. We will leave it alone. Sally is
7 going to look at the words and see if she can
8 make sure that there is not too much
9 specificity in them that reflects some of the
10 concerns that were raised here.
11 And we will move on to 3B. I do
12 think we have talked about perspective before
13 to reflect multiple settings. We have talked
14 about harmonization before. I'm not seeing a
15 whole -- well, Jeff, your table tent is up,
16 but I think it's still from before.
17 Is there anyone who has any
18 concerns about the implications of the words
19 or its presence or absence here as part of
20 usability?
21 All right. Let's move on to 3C.
22 I have to read it again, unless, Sally, you

1 can bring us up to speed quickly on why the
2 question mark?
3 MS. TURBYVILLE: Yes. So for this
4 one, this gets to how many similar measures
5 there are currently out that are endorsed.
6 And so an added criteria, even on the quality
7 side is that it is up to the submitter to
8 review all the existing NQF-endorsed measures
9 and provide information that shows that their
10 measure is distinct or somehow additive.
11 So it's adding to the whole
12 picture of the measures across the health care
13 systems. There is some question of the
14 applicability of this, since this is the first
15 resource use measure meant project. However,
16 one, there may be some measures out there that
17 are somewhat resource use, so maybe it applies
18 to those. If another readmission measure
19 comes in, we would want the measure developer
20 at submission, up front, provide the
21 information to the Steering Committee, why
22 they think their measure is worthwhile to be

1 used.

2 And then another thought was

3 because we are just focusing on resource use,

4 it might fit into this criteria or a similar

5 criteria to, and I think you all already

6 agreed to this, ask the measure developers to

7 look at the set of quality measures that are

8 endorsed and list the ones that they know have

9 been used with the resource use measure that

10 they are submitting.

11 Kind of slightly different ideas,

12 but that's the purpose of this particular

13 question mark. One, it seems it might be

14 applicable for few. We know we have some

15 readmission measures, so we would want them to

16 say why theirs is worthwhile.

17 And two, do we say why it adds

18 value to the existing quality measures as well

19 or not?

20 CO-CHAIR LOTZ: Barbara?

21 DR. RUDOLPH: I would just say

22 that I would just again take out that last

1 sentence, "in particular, existing measures
2 that inform the resource use measure in the
3 context of quality." Again, that just is
4 confusing to me.
5 I mean, I would certainly be fine
6 with the addition of, you know, suggesting
7 they review or add in what quality measures
8 have been used in conjunction with that
9 resource use measure.
10 CO-CHAIR LOTZ: Okay. Any
11 additional comment? Jeptha?
12 DR. CURTIS: Just a quick request.
13 I am just sort of picturing being on one of
14 these TAPs and, you know, the measure
15 developer will provide the information, the
16 ones that they are aware of, but literally the
17 list of endorsed quality measures and not
18 endorsed ones are in the thousands.
19 And is there a way that this staff
20 here could provide that crosswalk of like ones
21 that potentially could overlap with it?
22 CO-CHAIR LOTZ: The answer not

1 stated into a mike is yes, they can do that.
2 So when the staff does take the measures that
3 come in, they do look through them and, the
4 only word that comes to mind is, package them.
5 But they do, you know, make sure the fields
6 are filled, make sure things make sense and I
7 think that they can also make sure that, by
8 the way, did you know NQF has a measure on
9 this and, please, comment on it.
10 I don't think, you know, they are
11 submitted and then untouched until such time
12 as the Steering Committee reviews them or the
13 TAP reviews them. So the answer to that
14 question is yes.
15 Any further comment? All right.
16 Then we have a few new rows, new things to
17 consider under usability.
18 We are moving on to 3D and this
19 talks about maintaining the measure.
20 MS. TURBYVILLE: So I think this
21 is some of the crossover what is coming out of
22 the Task Force and I think we can circle back

1 after they meet with the CSAC over the next
2 couple of days. But there is a request that
3 the details are maintained enough so that the
4 users still know what is being measured, that
5 there aren't here is an endorsed measure and
6 here is actually what is going on.
7 And just adding that potentially,
8 that could include those underpinnings,
9 especially of the episode Groupers and it is
10 really to facilitate understanding and
11 complete transparency.
12 CO-CHAIR LOTZ: Sally, Helen spoke
13 about a three year cycle for reevaluation of
14 the measures. Is this something that NQF
15 expects of its measure developers, measure
16 owners to do in between that three year cycle
17 or this more relevant for the rereview of any
18 endorsed measures?
19 MS. TURBYVILLE: Absolutely during
20 those three years. If you have a substantial
21 change, you need to let NQF know and probably
22 do an ad hoc review. And anyone can submit

1 and say hey, by the way, I have been using
2 this measure and it has been changed
3 significantly and request it to have an ad hoc
4 review.
5 So it is automatic every three
6 years. We expect a thorough reevaluation, but
7 during those three years, they must be
8 maintaining it as well. Heidi, I don't know
9 if you want to add to that, but it is --
10 MS. BOSSLEY: Yes. Hi, I'm Heidi
11 Bossley. I'm in the same area with Sally, but
12 I'm working on the maintenance piece for the
13 quality measures. And we are hoping we mirror
14 pretty much the same process for these
15 measures as they go through.
16 The other piece that we will do
17 every year is ask them to tell us if they have
18 changed the measure. So is there a coding
19 update? Is there anything? And they will
20 provide that information to us.
21 We will then decide is this a
22 significant change? Does this need to be

1 reviewed by people? They added a whole new
2 concept and it's something that needs to be
3 looked at or is it just updating coding?
4 And we will do the same identical
5 thing for resource use measures as we do for
6 quality.
7 CO-CHAIR LOTZ: So, Heidi, you are
8 saying that's an internal NQF standard that
9 should be applied and communicated at this
10 time? I would just make it a little clearer
11 since it was unclear to me whether this is
12 something -- you know, what the periodicity is
13 of this review or what the expectations are.
14 Barbara? Oh, I'm sorry, David was
15 up first. Pardon me.
16 DR. PENSON: Two comments. The
17 first is when I saw including the Grouper, I
18 immediately interpreted that as the software.
19 I doubt very seriously if any of the vendors
20 can split the Grouper software logic. The
21 clinical logic makes a lot of sense. I mean,
22 I think you just literally ask them to

1 document the clinical logic, because the
2 software is going to sit side-wise, somewhere
3 around the side and you are not going to split
4 that into pieces.
5 The other thing that just occurred
6 to me, if we are talking about a three year
7 period, when does ICD-10 take effect? And
8 isn't that going to affect all of these
9 measures?
10 CO-CHAIR LOTZ: Inside of those
11 three years.
12 MS. TURBYVILLE: Right. We
13 actually have something. We did think about
14 that. We just convened a panel that looked at
15 what do we do with ICD-10. And probably
16 Ashlie can address it better. I mean, I was
17 on the panel, but I can't remember what we
18 said ultimately.
19 But it is going to the CSAC. We
20 are integrating it into our process. We have
21 set a deadline for when we anticipate
22 developers to provide ICD-10 as well as ICD-9.

1 And so that is moving forward well before the
2 2013 date.
3 CO-CHAIR LOTZ: Barbara?
4 DR. RUDOLPH: I had more of a
5 clarification question. Under the 3D, data
6 and result detail are maintained. I'm just
7 thinking about, you know, the measure
8 developer who may have data about specific
9 physicians, individual physicians, but who
10 doesn't have the intent to actually publicly
11 release it themselves.
12 What kind of -- I mean, will this
13 be identified data? Are there any thoughts as
14 to how this would be managed?
15 MS. TURBYVILLE: I think that's an
16 excellent question and I think we will
17 communicate that to Karen Pace with the Task
18 Force and it may have already been changed.
19 Again, it is unfortunate that these are
20 happening concurrently, but that's a very good
21 question.
22 CO-CHAIR LOTZ: So given that we

1 are somewhat subject to another group or not
2 subject, but we are bumping up against, it
3 sounds like, you know, I share your concern,
4 Barbara, that that probably doesn't belong in
5 this group. We will revisit this. But keep
6 a note that we don't think it belongs here.
7 MS. TURBYVILLE: Yes.
8 CO-CHAIR LOTZ: Or Barbara and I
9 don't think it belongs there. Dolores?
10 MS. YANAGIHARA: The way I was
11 interpreting that is not so much the data or
12 the results of the measurement itself, but the
13 data and result detail in terms of what is the
14 result that you are measuring? What are the
15 data you need for measuring and then all of
16 that is capped in such a way that when someone
17 asks to use it, it is readily available to
18 them.
19 That's how I was interpreting
20 this. Because have tried to get measures from
21 measure developers and it is a lot of times
22 not easy to do. They don't have the level of

1 detail you need to actually implement it.

2 So that's how I was reading this,

3 that they need to maintain that in such a way

4 that they can send it to people who want it or

5 purchase it or whatever the arrangement is.

6 But I mean, that's how I was interpreting

7 that.

8 MS. YANAGIHARA: Yes, yes, and I

9 think that's good.

10 CO-CHAIR LOTZ: Yes.

11 MS. YANAGIHARA: So the results of

12 use of the measure as opposed to the actual.

13 CO-CHAIR LOTZ: Like the

14 specification.

15 MS. YANAGIHARA: Yes.

16 MS. TURBYVILLE: Really the

17 implementation detail, yes.

18 CO-CHAIR LOTZ: All right. We

19 need to speak into the microphone. It doesn't

20 count if you yell. You have to speak into the

21 microphone. It doesn't count if you are

22 passionate.

1 DR. RUDOLPH: I would like to see
2 the implementation details there instead of
3 just data and result details.
4 CO-CHAIR LOTZ: Okay.
5 DR. RUDOLPH: Because that's
6 really different.
7 CO-CHAIR LOTZ: David, are you up
8 again or not yet down? All right. Tom?
9 DR. ROSENTHAL: Just a clarifying
10 question. Do these measurements not become
11 part in effect the public domain once they are
12 created or do the developers in effect own
13 them forever?
14 DR. RUDOLPH: They maintain them.
15 DR. ROSENTHAL: Well, I guess I
16 had a mental picture that somebody submits a
17 measure, maybe it's my stupidity, but I had a
18 mental image that once, you know, the CMS
19 measurement for aspirin at the time of heart
20 attack enters the domain, public domain in the
21 sense of having been published by the NQF,
22 what role do they maintain in maintaining some

1 private thing? I guess I don't get it.
2 MS. BOSSLEY: So I can answer for
3 quality measures. I think we need to figure
4 out what is going to happen with resource.
5 DR. ROSENTHAL: It might not be
6 the same.
7 MS. BOSSLEY: Yes, it might not be
8 the same. For quality measures, we need
9 someone to own and steward that measure. And
10 so it is typically the developer who commits
11 to providing the details, the specifications,
12 the codes to NQF and to allow it to be
13 published publicly and available publicly for
14 others to use.
15 And they also commit to
16 maintaining that measure annually and every
17 three years for maintenance. Does that help
18 answer your -- I mean, it literally is we are
19 asking them to step up, make sure it is up to
20 date, maintained and also the other
21 expectation is is that detail of the coding,
22 everything that is endorsed is publicly

1 available for people to use and to access.
2 I don't know if I'm answering your
3 question.
4 DR. ROSENTHAL: I guess I'm trying
5 to imagine not knowing enough about all of the
6 quality measures, I'm trying to imagine the
7 owners of each one of those.
8 MS. BOSSLEY: Yes.
9 DR. ROSENTHAL: So can you give us
10 even an example of who owns certain ones?
11 MS. BOSSLEY: Sure. So several
12 measures are -- well, the main measure
13 developers are NCQA, National Committee for
14 Quality Assurance, CMS is also a measure
15 developer. There are several specialty
16 societies who are. There is the AMA Physician
17 Consortium for Performance Improvement. It is
18 not a small list.
19 And so several have hundreds of
20 measures that are endorsed right now and they
21 are responsible for maintaining them and some
22 have a handful.

1 DR. ROSENTHAL: Okay. Thank you.
2 CO-CHAIR LOTZ: Sally, did you
3 want to say something otherwise?
4 MS. TURBYVILLE: I did want to add
5 that as Helen mentioned, there is the
6 potential for some of these commercial vendors
7 to not have their entire specification out in
8 the public. They just provide, say this
9 measure is endorsed and here is the link how
10 you can come and talk to us about using our
11 specifications.
12 So it's a special proprietary
13 agreement that happens through our legal
14 folks, et cetera.
15 CO-CHAIR LOTZ: Barbara?
16 DR. RUDOLPH: Yes. I was just
17 going to explain that some of the measures,
18 the more sophisticated ones have coefficients
19 that need to be updated every year. And so
20 you can't just put the measure out there and,
21 you know, let it sit by itself. You have to
22 have somebody, you know, massaging it and

1 doing that analysis and putting out the new
2 coefficients so the end users can continue to
3 use that measure.
4 CO-CHAIR LOTZ: Ethan?
5 DR. HALM: So operationally, if we
6 review a measure, you know, at time one and
7 then the developers keep tweaking the model
8 and so we review it at one point in time, but
9 they keep changing the model, how do we handle
10 that? I mean, that doesn't come up with the
11 quality measures or does it?
12 MS. TURBYVILLE: It does. And --
13 DR. HALM: So do we say that these
14 are endorsed as of this date? You know,
15 accessed as of?
16 MS. TURBYVILLE: They are endorsed
17 as they were specified when you reviewed them.
18 MS. BOSSLEY: Right. But when
19 that changes, right, it should go through an
20 ad hoc review.
21 MS. TURBYVILLE: Yes.
22 MS. BOSSLEY: So that's part of

1 our process. So part of the process is if
2 they come in and they have changed it and I
3 think staff will have to -- we are usually the
4 first ones to look at it and determine whether
5 we think there is a significant enough or
6 material change, that then goes to experts, it
7 goes through a process and goes out for
8 comment.
9 DR. HALM: But does -- but is the
10 burden then on NQF to monitor that? So let's
11 say the science of attribution will get
12 hopefully better. And as people do that, that
13 could have critical impact on the validity of
14 a measure, unless sort of a don't ask/don't
15 tell thing, unless someone is really sleuthing
16 for these changes, I mean, maybe you deal with
17 this all the time.
18 MS. BOSSLEY: Right.
19 DR. HALM: But it strikes me as a
20 moving target in this case more so than in
21 quality measures.
22 MS. BOSSLEY: Part of the

1 agreement that we agreement that we enter into
2 with the stewards is that they are responsible
3 for informing us. Now, if we become aware of
4 it, we will also do some fact-finding and see.
5 But it is really part of their responsibility
6 to make that known to us and to others or we
7 can always be told by the public.
8 I mean, there is multiple avenues
9 that can alert us to this.
10 CO-CHAIR LOTZ: As well as the
11 safety net of three year review.
12 MS. BOSSLEY: Right.
13 CO-CHAIR LOTZ: So that would be
14 the outside limit of a more comprehensive
15 review. David?
16 DR. REDFEARN: With regard to the
17 commercial vendors, I would not expect to see
18 lots of changes in these things once they are
19 proposed. I can tell you as one of the major
20 customers of Ingenix and their Symmetry
21 products, universally, Anthem, WellPoint,
22 Aetna, CIGNA, everybody has told Ingenix,

1 please, stop. Don't make any changes for the
2 next three years, because we all see ICD-10
3 coming, too.
4 They are going to crosswalk ICD-
5 10. The logic is not going to change. Every
6 time they update their system, we have to go
7 back to our systems. It takes us as a company
8 a year to make these implementation changes,
9 because they are built into the infrastructure
10 of the company.
11 Universally, all of the major
12 customers of these vendors are saying don't
13 make changes. Stop, hold in place. So once
14 these things are out, I don't think there is
15 a heck of a lot of risk of these things
16 changing.
17 CO-CHAIR LOTZ: Barbara?
18 DR. RUDOLPH: Yes. And at any
19 point a party, interested party can make a
20 request for an ad hoc review as long as they
21 demonstrate a certain amount of information
22 about it that, in fact, this needs to be

1 updated or that needs to be updated. They can
2 actually trigger that.
3 So you know, there is a lot of
4 different eyes looking at what is happening in
5 the measurement world.
6 CO-CHAIR LOTZ: All right. 3D is
7 about the maintenance of a measure. Everyone
8 take a quick look at it again. Reflect on the
9 conversation we just had. We want some
10 additional clarity around what is meant by the
11 result.
12 There was an earlier comment about
13 grouper maybe not belonging, as an example,
14 but focused just on clinical change that might
15 drive it. Is that what you got? Am I missing
16 anything? Does anyone have anything that is
17 critical that wasn't in that summary?
18 All right. Again, you will see it
19 on paper, so if you are feeling a little
20 pushed, you are being pushed, but you have a
21 chance to come back to it in the next two
22 weeks.

1 3E, again, a new measure. Sally,
2 can you just quickly tell us why it is here,
3 because I'll have to read it as well?
4 MS. TURBYVILLE: So this is after
5 and this may be too early for the resource use
6 measures. I believe this is coming up because
7 there is a desire that once a measure is
8 endorsed, that the measure developer
9 demonstrate that and I guess it could be
10 through pilot testing as well.
11 So previous to actual endorsement,
12 that it achieves stated purpose and objective.
13 I'm a little -- it sounds a little bit like
14 some of the scientific acceptability
15 discussion that was had. And so that was the
16 note in there about perhaps we just need to
17 provide further guidance to the submitters on
18 what they might submit.
19 You know, one thing that we want
20 to not only make sure they submit what they
21 need to, one of my concerns is they are going
22 to submit more than is necessary and it will

1 be volumes and volumes and make it very
2 onerous to actually evaluate the measures.
3 But I think our subgroup can get
4 to some of this. We can look at whether or
5 not this fits in usability and make changes as
6 needed.
7 CO-CHAIR LOTZ: Barbara, are you
8 up for comment?
9 DR. RUDOLPH: Oh, no.
10 CO-CHAIR LOTZ: So comment on
11 piloting. Do ahead, David.
12 DR. REDFEARN: I think we just
13 talked about this before.
14 CO-CHAIR LOTZ: Yes.
15 DR. REDFEARN: But my expectation
16 certainly in the commercial carriers if they
17 have got tons of data, they should be doing
18 piloting. They should be able to demonstrate
19 this stuff on real data and say we ran this
20 logic on 30 million members of this population
21 characteristic and this is what we see in
22 terms of the distribution and out output.

1 They should be able to do that.
2 I don't know that you can insist
3 on all of the measure developers doing
4 something like that, but I would fully expect
5 the Ingenix, the Thompsons to do that.
6 CO-CHAIR LOTZ: Well, we have as
7 part of our scientific acceptability say we
8 are insisting on them piloting it. But does
9 it also belong here in usability or is it
10 sufficient in that area? Paul?
11 DR. BARNETT: So the only reason
12 to have it here in addition to where it is in
13 the scientific acceptability is if we are
14 asking them show us how it has been used
15 practically in effected decisions.
16 CO-CHAIR LOTZ: Yes.
17 DR. BARNETT: And otherwise, it
18 doesn't really belong here. So I think that
19 it could perhaps be just rephrased a little
20 bit differently to say that is what practical
21 applications. You know, he was using it. I
22 mean, we could just even ask that. Who are

1 the current customers? How many covered lives
2 have been evaluated with this? You know, some
3 practical something like that.
4 CO-CHAIR LOTZ: Additional
5 comments beyond some specificity about what we
6 are piloting here, which is the usability?
7 All right. We've got one more row
8 that says add issues around peer group
9 comparisons. We talked about comparisons.
10 MS. TURBYVILLE: Yes. So this is
11 when I was trying to grapple with when we were
12 thinking about the steps that would and would
13 not be subject to evaluation. So I think this
14 can be turfed to the sub-group and then we can
15 put the criteria whether it is in usability or
16 whether it is in scientific acceptability, et
17 cetera, which criteria might be needed.
18 So we could opt to ignore that for
19 now and just wait for the sub-group to get
20 back with how something like peer group
21 comparison would be evaluated. Would it be in
22 scientific acceptability? Would it be in

1 usability, et cetera? I have no opinion right
2 now other than what we have heard the past day
3 and a half.
4 CO-CHAIR LOTZ: Okay. So we will
5 leave it for the sub-group who can toss it
6 underneath here, but discuss it at greater
7 length, both how to go about it and where it
8 belongs in the document.
9 Okay. All right. From there, we
10 will move on to the fourth criteria, which is
11 feasibility.
12 We are starting out with our
13 overarching comment about feasibility. There
14 are no changes that Sally has incorporated
15 into the document, based on our prior
16 conversation. Any comment now? Bruce?
17 CO-CHAIR STEINWALD: Well, one
18 general comment is, you know, we have said
19 several times that resource measures that are
20 earlier stage of development than quality
21 measures and that being so, one might expect
22 that the burden of developing such measures

1 early on is like the burden of developing
2 anything that is new early on and the burden
3 is always higher at the earlier stages until
4 something is put into more widespread usage
5 and then the burden is reduced.
6 So I wonder if we don't want to
7 use language that says that the burden right
8 away has to be de minimis, which is kind of
9 the way it sounds, some of what is written
10 here sounds.
11 CO-CHAIR LOTZ: Barbara?
12 DR. RUDOLPH: Well, my thought is,
13 I mean, while these measures are new to NQF,
14 they certainly aren't new to the measurement
15 world. People have been measuring costs for
16 a long time and so I don't know that we need
17 any special exemptions here.
18 Undue burden, I guess, to,
19 obviously, someone who is going to be
20 publishing this kind of information. If you
21 were going to -- if you were an end user of
22 the measure, say the measure is developed by

1 someone, you are going to have to have access
2 to data and a large volume of it in order, you
3 know, so that -- and it has got to be
4 electronic or you aren't going to be able to
5 do this kind of work.
6 I don't think that that's really
7 burdensome.
8 CO-CHAIR STEINWALD: Okay. Well,
9 just I'll subside on this, but, you know,
10 Medicare claims data are readily available
11 without undue burden. But if that's all that
12 measure developers are going to base their
13 measures on, then we are not progressing as
14 far as we would like to.
15 DR. RUDOLPH: Let me just react to
16 that. I think these measures will also be
17 used by the 10 or 12 states that --
18 CO-CHAIR STEINWALD: Yes.
19 DR. RUDOLPH: Well, maybe not.
20 But they may be used by the 10 or 12 states
21 who have all payer claims data. They would
22 have the capacity to do this, whether or not

1 they actually would do it, particular for
2 physicians. Physicians is kind of doubtful.
3 CO-CHAIR STEINWALD: Okay.
4 CO-CHAIR LOTZ: Well, I think,
5 too, as Joe pointed out earlier, once they are
6 out there, people may suddenly find them
7 reasonably attractive and applicable.
8 CO-CHAIR STEINWALD: All right.
9 CO-CHAIR LOTZ: Let's move on then
10 to 4A. And again, what we have is just an
11 amendment that says for resource use measures,
12 et cetera. So again, this is under the
13 umbrella of feasibility.
14 Sally, did you want to say
15 something? Mic.
16 MS. TURBYVILLE: No.
17 CO-CHAIR LOTZ: Mary Kay?
18 DR. O'NEILL: We did touch on
19 earlier the idea that there are services
20 delivered to patients within the context of
21 practices that aren't coded for or paid for
22 explicitly, counseling and care coordination

1 and things like that.

2 And I think that those kind of

3 variables may be the thing that drives the

4 difference in outcome in the long run, so we

5 shouldn't get ourselves in a box whereby the,

6 you know, claims data is all we have to go on.

7 So I think that that would hamper

8 our ability to truly understand resource

9 utilization impact if we limited ourselves

10 that way.

11 MS. TURBYVILLE: Can I?

12 CO-CHAIR LOTZ: Yes, go ahead.

13 MS. TURBYVILLE: And I'm glad you

14 brought that up, Mary Kay, because, in fact,

15 that's what this 4A is trying to get at, that

16 it's not just about the claims data. It's

17 about the care delivered as a byproduct of

18 care. So that's the source of all of these

19 measures, so I think your point is still right

20 on.

21 I guess my question would be

22 whether or not we need to expand that

1 language? But it is meant to not -- to be
2 more encompassing rather than more restrictive
3 in that manner.
4 DR. O'NEILL: It's just that when,
5 I guess maybe in my world, we look at data
6 elements, these are things that are frequently
7 not data elements. I mean, they are in the
8 cost of delivering care to the institution or
9 the cost of managing a population to a payer,
10 but they aren't -- they don't end up in little
11 boxes on a spreadsheet.
12 CO-CHAIR LOTZ: Steve?
13 MR. PHILLIPS: Yes, I actually was
14 going to raise the same comment. I guess
15 actually in the context of 4B, where we
16 scratched out or proposed to scratch out that
17 the data are not an existing electronic
18 source, but with the same idea, that there may
19 be services that are not currently being
20 picked up on some of the administrative data.
21 I don't know. I don't have any
22 good suggestions for how you would get them,

1 but I think that's part of what we want to
2 encourage here is for people to think
3 creatively about how to pick these things up.
4 And I'm just a little concerned that if we
5 limit it to things that are available on
6 electronic sources, that then it may preclude
7 some of that.
8 CO-CHAIR LOTZ: David?
9 DR. REDFEARN: I jumped ahead to
10 4D, too.
11 CO-CHAIR LOTZ: That's fine. We
12 can consider them together. Don't feel
13 limited.
14 DR. REDFEARN: I mean, electronic
15 sources, I don't know quite what that means.
16 There is a whole dimension there. You could
17 say very explicitly it has to be in one of the
18 ANSI data sets for data transmission or there
19 has to be a standard coding system like LOINC
20 codes for lab visits.
21 I mean, it could be very, very
22 explicit or you could just say in some

1 electronic form, so you are not shuffling
2 pieces of paper. I'm not quite sure what we
3 are intending here.
4 You could be explicit and say it
5 has to be an ANSI standard data set, that's
6 the universe. It doesn't mean it's populated,
7 but that's the universe. But that sort of
8 restricts us to what is available now. It's
9 not aspirational for what you might get in the
10 future.
11 But this is a little vague for my
12 point of view in terms of understanding what
13 it really means.
14 CO-CHAIR LOTZ: Bill Rich?
15 DR. WILLIAM RICH: I agree with
16 Mary Kay. And David's answer, I think, will
17 help a great deal, because there are many
18 innovative projects out there in the
19 commercial side and pending in Medicare where
20 a lot of these services are coded, but they
21 are not billed, because they are not paid for.
22 So we should encourage people in

1 projects to collect that data. And I don't
2 know the verbiage that you would use, but I
3 think it's imperative that we do that, both
4 home concept and many of the commercial
5 products have chronic care models up and
6 running now.
7 So somehow, we have to have
8 verbiage that encourages them to collect the
9 data. It's not going to be administrative
10 data, but perhaps David's thing captures that.
11 CO-CHAIR LOTZ: Tom?
12 DR. ROSENTHAL: When I read A and
13 B together in its current format, it would
14 seem to me to be almost entirely limited to
15 claims data at the current point. I mean, but
16 if we don't intend it to be that, then we have
17 got to rewrite one or the other of them. And
18 as I read 4A independently, something that is
19 generated as a byproduct of care, in fact,
20 could be progress notes.
21 I mean, you could have chart
22 reviews and a variety of other things that

1 would get you 4A. But if you add 4B, which
2 requires it to also simultaneously be
3 electronic, I think you immediately take it
4 into the realm of the only thing that is going
5 to make it is going to be claims data.
6 And if we don't intend it to be
7 that, then we have got to modify one or the
8 other of the two.
9 CO-CHAIR LOTZ: Paul?
10 DR. BARNETT: Yes. When we look
11 at these two elements, we don't want to
12 overlook the fact that we need the data on the
13 providers, you know, what their specialties
14 are and what their scope of practice is and
15 all that.
16 CO-CHAIR LOTZ: Yes.
17 DR. BARNETT: And that's another
18 data set that has to be got that won't be
19 covered by these.
20 CO-CHAIR LOTZ: Dolores?
21 MS. YANAGIHARA: Electronic data,
22 I mean, we kind of use the term broadly to be

1 anything that is electronic. It could be an
2 EHR. It could be a case management system.
3 I mean, I don't think very many programs are
4 run on paper. I mean, I know there is a lot
5 of paper charts still.
6 But, I mean, in terms of case
7 management or those kinds of programs, you are
8 going to have, usually, an electronic format
9 that potentially could be, you know, used as
10 electronic data to supplement administrative
11 claims and counter data.
12 CO-CHAIR LOTZ: Tom?
13 DR. ROSENTHAL: I think we can
14 certainly say that electronic data is
15 preferable, but it doesn't sound to me like we
16 are ready to say it's obligatory, even though
17 that, yes, your point is well-made that there
18 are these one-off systems, but they are
19 certainly not as universally available as the
20 byproduct of care is as a billed claim. And
21 that's just because that's how you get your
22 money in the current environment.

1 I guess that's one of those
2 negative or possibly even positive attributes
3 of having a fee-for-service system.
4 CO-CHAIR LOTZ: Mary Kay?
5 DR. O'NEILL: Well, there is a lot
6 of work that goes on in practices that doesn't
7 get recorded in any way, because it is more
8 expensive to record it than, you know, if
9 there is little or no payment for it. So
10 there is actually a lot of variability in
11 practice design that has a significant impact
12 that is not recorded.
13 CO-CHAIR LOTZ: Barbara?
14 DR. RUDOLPH: Yes. I just wanted
15 to second Dolores' statement, because when I
16 think of the electronic data sources, that can
17 be registry data, that's electronic. It can
18 be birth and death data that is electronic.
19 It can be claims data. It could be the claims
20 attachment information. It could be the
21 provider files from Medicare. It could be any
22 number of things.

1 The idea is that we won't want to
2 be asking health care providers to go back to
3 paper charts to look up 15,000 records. You
4 know, I think to be practical, it seems like
5 it has to be in some type of electronic
6 format, standardized preferably.
7 CO-CHAIR LOTZ: And couldn't a
8 well-articulated measure of resource use/need
9 drive payment policy? I mean, this isn't all
10 about collapsing payments, but if there is a
11 need to do things differently by way of
12 eventually leading to efficiency, don't we
13 want to demonstrate that?
14 So again, I don't know how to
15 capture what is being done right now that is
16 not being paid for, but it seems to me that
17 there are some things that we are doing now
18 that ought to get paid for concurrent with
19 eliminating some things. I'm not sure how to
20 do that though. Paul?
21 DR. BARNETT: So I think one way
22 to deal with this is to be explicit by

1 explicitly talking about the things that we
2 just said, which are, you know, that we want
3 the electronic or claims data, we expect to
4 the be predominant source, but that there is
5 going to be some reflection of resources use
6 and production of services that aren't billed
7 for and that there may be some essential
8 elements, but they are going to be a minority
9 of the data that are going to be gathered in
10 some other way, e.g., the information about
11 the providers that are being profiled.
12 CO-CHAIR LOTZ: I think the aim is
13 to, you know, not be administratively
14 burdensome. So again, however we capture
15 that, you know, just don't make it so onerous
16 that it is not doable. Steve, sorry. Yes, go
17 ahead.
18 MR. PHILLIPS: Well, I was just
19 going to say, I mean, I think I guess I would
20 respond to that, that that can be part of the
21 evaluation of the measures, that you maybe let
22 them -- let things through that, you know,

1 maybe strictly speaking people not interpret
2 as the standard electronic source for the
3 data.
4 But that through the evaluation if
5 whatever they are proposing to do is
6 burdensome, then that would be taken into
7 account.
8 CO-CHAIR LOTZ: Go ahead.
9 CO-CHAIR STEINWALD: Yes. I'll
10 make a grandiose statement. And we're nearing
11 the end of the second day, so to really feel
12 important, if we might -- could you imagine us
13 putting out there some guidelines or criteria
14 that could encourage the development of
15 electronic forms of data that don't presently
16 exist or don't uniformly presently exist?
17 And there are some examples out
18 there. You know, in Medicare, one of the
19 problems that existed for a long time is that
20 there hasn't bee a whole lot of data on
21 Medicare's Part C providers and the encounter
22 data -- on the encounters that they perform,

1 because since they are not paid, you know,
2 this is an irony, on a fee-for-service basis,
3 therefore, there are no claims data as a
4 byproduct of service delivery. Therefore,
5 there is a limited ability to actually analyze
6 the services, both the quality and efficiency
7 of the services provided.
8 Now, I know that there are people
9 who would say well, that's not complete true,
10 because there are these other data sources,
11 but it is not routinely developed as a
12 byproduct, here we say, of care, but, in fact,
13 a lot of data is generated as a byproduct of
14 payment.
15 And if we can conceive of an
16 evolving health care delivery system where we
17 are going to have new forms of delivery and
18 payment, where we want to rely less on fee-
19 for-service as the predominant mode of
20 payment, therefore, we want to rely less on
21 data that are available as a byproduct of fee-
22 for-service payment, then it seems to me that

1 the development of new kinds of data systems
2 might be in this sort of brave new world that
3 we envision.
4 And that we shouldn't, therefore,
5 I mean, there has to be a link now, confine
6 ourselves to recommending the development of
7 measures that are generated as a byproduct of
8 current delivery and payment systems.
9 CO-CHAIR LOTZ: Got that, Sally?
10 CO-CHAIR STEINWALD: Well --
11 MS. TURBYVILLE: Yes, I got the
12 gist of it.
13 CO-CHAIR STEINWALD: Yes.
14 MS. TURBYVILLE: I mean, it's a
15 very important conversation. I guess when I
16 thought -- think of this statement of
17 byproduct of care, it is specifically one of
18 the reasons it is stated as such is it's not
19 just about what you are trying to do for
20 payment.
21 So but I understand this. It is
22 clearly being interpreted differently, so I

1 think that is very important feedback. And I
2 think to the point about making sure that we
3 are acknowledging that there are other data
4 sources besides claims and, you know, that
5 even the term electronic sources seems to be
6 misleading in trying to make sure that we are
7 encompassing the entire universe as it is and
8 the entire potential universe coming that
9 would be of interest for resource use
10 measures. So we will play with that.
11 CO-CHAIR LOTZ: Jack?
12 DR. NEEDLEMAN: One of the things
13 I heard was the whole issue of aspirational in
14 terms of we are going through a process, for
15 example, of developing electronic health
16 records. And one of the issues is how much of
17 that -- you know, the ability of that data,
18 those systems, to actually routinely spinoff
19 reports, which have information on resource
20 use beyond what we have currently been getting
21 for billing would be a very useful thing.
22 Places that are completely paper

1 would have a very high bar, very low
2 feasibility to generate certain kinds of
3 measures, while places that are completely EHR
4 with good ways of harvesting that data and
5 reanalyzing it might have a very low bar.
6 And what I heard Bruce asking for
7 was, basically, that we be somewhat
8 aspirational in terms of laying out -- being
9 prepared to endorse things that will
10 potentially be available through well-designed
11 EHRs, but which may not be readily available
12 right now.
13 And I think that's a reasonable
14 standard for thinking about this in terms of
15 feasibility.
16 The other thing is the feasibility
17 standard in terms of strictly being a
18 byproduct, I know in some measures has not
19 been an absolute bar to endorsement. So, for
20 example, in the nursing performance data set,
21 the whole pressure ulcer prevalence measure
22 that is in the NDNQI and the CalNOC nursing

1 data sets, which requires a monthly separate
2 data collection effort, was endorsed as a
3 measure.
4 So I think this issue of
5 feasibility is one that has been one that is
6 where special data collection has not been
7 completely ruled out in prior measure efforts
8 and it represents one of those areas where how
9 much burden is being imposed for how valuable
10 data is a tradeoff measure and not an absolute
11 bar measure.
12 CO-CHAIR LOTZ: All right. We
13 have had a couple of new summary statements.
14 I know I have written down a couple of them.
15 Are you okay if we move on?
16 MS. TURBYVILLE: Yes.
17 CO-CHAIR LOTZ: Is the group okay
18 if we move on? All right.
19 Then we will move, where are we
20 at, 4C, don't require what you don't need.
21 Comments? Barbara?
22 DR. RUDOLPH: I'll just do this

1 out of context, because this is something that
2 bugged me on the CSAC. We were getting in
3 measures that were being measured using
4 administrative data up to the point of the
5 exclusions.
6 And then it would require chart
7 review for the exclusions. And this is why
8 this is here, because we don't want measures
9 where the entire measure set is looking at,
10 you know, using an administrative data source,
11 but then somebody has an anecdotal case that
12 they want to be able to tap into and exclude
13 from measurement, so that's why this is here.
14 CO-CHAIR LOTZ: Does that stand
15 clearly without any additional need to amend
16 for our purposes? That yes was not said into
17 a microphone, so I'll say it on behalf of the
18 group and move us on to 4D.
19 Again, there are no amendments
20 from prior conversations. So an ability to
21 audit, to verify, to clean up, does it require
22 being here? Does it require any amendments?

1 Does it speak clearly? Don't disengage yet
2 guys, we're not done.
3 DR. BARNETT: I think D and E are
4 fine.
5 CO-CHAIR LOTZ: A motion has been
6 made to jump ahead to E. No, that's fine.
7 Why don't -- we will go ahead and look at them
8 both then, and then, you know, give you a
9 second to read it and then again, the same
10 thing, you know, does it stand clearly as is?
11 Does it require amendment?
12 Joe, I can hear you thinking.
13 DR. STEPHANSKY: Well, if we knew
14 all the unintended consequences ahead of time
15 at the time of measure submission, things
16 would be cool. But I guess it's a question of
17 when the unintended consequences arise, does
18 that force some sort of review here at NQF?
19 That would be my concern.
20 CO-CHAIR LOTZ: Yes. Jack, go
21 ahead.
22 DR. NEEDLEMAN: Can somebody offer

1 an example of what unintended consequences
2 means in this context, having eliminated the
3 gaming language earlier?
4 CO-CHAIR LOTZ: Bill Rich?
5 DR. WILLIAM RICH: I can give you
6 some discrete examples that were never
7 anticipated with other resource use measures.
8 Treatment of glaucoma. There is one ICD-9
9 Code. There is no way to differentiate, you
10 know, levels of disease. And therefore, every
11 glaucoma specialist in the United States has
12 a very high level. Those treating lower
13 levels of disease are favorably tiered.
14 CO-CHAIR LOTZ: Okay.
15 DR. WILLIAM RICH: And tremendous
16 access problems. It became a national
17 problem. No one anticipated this. No one
18 realized that their risk adjustment failed
19 because there was no granularity in ICD-9. So
20 there is a very pragmatic example.
21 MR. JONER: In dealing with
22 attribution models with some payers, we had

1 problems we didn't realize until after we
2 started accumulating the data over a number
3 of, well, like 18 months. It took quite a
4 while for the problems to show up.
5 CO-CHAIR LOTZ: I'm going to let
6 Ashlie jump in here for just a moment, folks.
7 MS. WILBON: I just have a quick
8 add-on and actually this would have been a
9 great Heidi question. She just walked out.
10 But in terms of what NQF does, I think, Joe
11 posed the question earlier for measures that
12 have unintended consequences, we do actually
13 have a process that we -- called the ad hoc
14 review that generally measures that are either
15 brought to our attention by public members
16 that have had unintended consequences do get
17 reviewed at that point in time.
18 We do a special expedited review
19 process to review them and make sure that, you
20 know, the unintended consequences are
21 addressed. And if the measure needs to be
22 retired or adjusted or whatever, that that is

1 done. So just a little tidbit. Thanks.
2 CO-CHAIR LOTZ: David?
3 DR. REDFEARN: Two comments.
4 First is that if they are unintended, how do
5 you know them beforehand? And if you know
6 them beforehand, they are not unintended.
7 That's the first.
8 And the other thing is the
9 flipside of that, I used to have a college
10 professor that when he didn't have his final
11 exam grades done for us, we would say due to
12 the usual unforeseen circumstances. The usual
13 unforeseen circumstances, they are not ready.
14 So in some sense, I mean, it's
15 sort of a sensitivity analysis. You know,
16 what are you doing? What is the complexity of
17 the data? And how much variability is out
18 there that you can't get your arms around?
19 That's, I think, what this is going at.
20 But if you can predict these
21 things, then they are not unanticipated. You
22 should control them.

1 CO-CHAIR LOTZ: Barbara?
2 DR. RUDOLPH: Yes. Speaking to
3 that, LeapFrog put forward a length of stay
4 measure and because we knew that we did not
5 want patient safety or quality to go down
6 because hospitals were competing on length of
7 stay, we used readmission rates as an inflater
8 of the length of stay to prevent that perverse
9 consequence.
10 CO-CHAIR LOTZ: Bill?
11 DR. WILLIAM RICH: I would like to
12 go back to make a comment on 4C once we are
13 done with these two.
14 CO-CHAIR LOTZ: Okay. Ann?
15 MS. HENDRICH: I just wanted to
16 add-on to what has already been said around
17 unintended consequences. I think so many
18 times we don't have a follow-up to these
19 measures to know longer term unintended
20 consequences.
21 An example that comes to mind for
22 me clinically is not unlike the pressure ulcer

1 example where there is not good data
2 collected, but was around pain scores and how
3 we were auditing every patient for their pain
4 score. And unintended consequences was when
5 demerol went off the shelf and was replaced
6 with dilaudid. We had patients getting ten
7 times the recommended dose. And because there
8 is no long-term measurement of that
9 clinically, it is causing patient harm.
10 So I think as we think about these
11 measures, are we creating something for an
12 improvement purpose in measurement and how do
13 we know after the fact when the measure starts
14 being collected is there a follow-up that is
15 done? And most of these measures I don't
16 think have that.
17 CO-CHAIR LOTZ: So perhaps we are
18 speaking of the measure developer saying,
19 obviously, if it's right now, it is
20 unintended. It's not unintended, but
21 somewhere between now and the next three year
22 cycle. That's an NQF question. I don't know

1 the answer.

2 MS. HENDRICH: Yes, maybe there is
3 some way to go back and take a look based on
4 we don't know what we don't know until it is
5 implemented.

6 CO-CHAIR LOTZ: Sally, did you
7 want to comment? Otherwise --

8 MS. TURBYVILLE: I was just going
9 to add to what Ashlie said that, you know,
10 there is that potential. And, you know, maybe
11 something to further think about is they make
12 this ad hoc process more robust, but there is
13 always an opportunity for the users of the
14 data and say hey, this is what is happening
15 with the measure right now. Can you do an ad
16 hoc review? This is what we found, et cetera.

17 So we welcome that input in
18 addition to the annual request from the
19 measure developers for changes and the
20 automatic three year complete review for
21 endorsement.

22 But, indeed, it is tricky once the

1 measures start getting used. We don't have
2 complete control of how they are used. That
3 is very true.
4 CO-CHAIR LOTZ: Bill? Oh, Ashlie,
5 did you want to jump in again?
6 MS. WILBON: Yes. Sorry, I just
7 had a quick add-on to piggyback to what Sally
8 was saying. And actually, there is an effort
9 through our Strategic Partnerships Department
10 right now that is actually doing an inventory
11 and an evaluation of the measures, the
12 endorsed measures that are being used.
13 I think part of what Sally was
14 saying is we endorse the measures. We put
15 them out there for public use, but we don't
16 always know all the programs and all the uses
17 that -- all the different uses that the
18 measures are being used for in different
19 programs.
20 And so the ability to kind of
21 follow-up and say we know this program is
22 using it this way and would have been

1 unintended consequences is something that
2 hasn't always been in our realm, but we are
3 working, we are creeping into that area now in
4 some other efforts.
5 CO-CHAIR LOTZ: Bill Golden?
6 DR. GOLDEN: Yes. I guess this
7 discuss just reinforces my concerns about
8 public reporting when you have an evolving
9 technology. And measures will always have
10 unintended consequences. The less we know
11 about a measure and we endorse them, the more
12 likely it happens.
13 There are many, many examples of
14 it. The pneumonia measure for antibiotics
15 within four hours was based on so-so science.
16 And what happened was everybody and their
17 mother was getting, and their mother's too,
18 antibiotics as soon as they hit the ER door,
19 whether or not they had pneumonia. So we had
20 over-treatments of pneumonia all over the
21 country.
22 There are data, this is a negative

1 one, but ARC has some measures about
2 disparities. And Arkansas has its problems
3 with health care. And we were given one of
4 the best ratings in the country for having no
5 disparities for this, this and this.
6 And, you know, I was asked to
7 comment on the disparity report and I said
8 well, part of your problem is that in this
9 particular measure, it is correct that our
10 African-American rate of complications is the
11 same as the national rate.
12 Our problem is that our white
13 complication rate was much higher than the
14 average white, so our disparity rate was much
15 lower, because our white population wasn't
16 doing very well.
17 So I mean, there are all these
18 things out there and it creates distortions,
19 which is the reason I have concerns as we move
20 forward about public reporting. It's a
21 slippery slope to let issues that we don't
22 have methodologic handles on become a public

1 entity. And then we learn after the fact when
2 misinterpretations occur.
3 CO-CHAIR LOTZ: Paul?
4 DR. BARNETT: So just to the
5 practical matter, what do we put in the boxes
6 on the paper? I still think 4D and E are good
7 and should stand. And the only thing I can
8 think of we could ask from the measure
9 developer in addition is not only, you know,
10 what have you already done to consider these
11 issues about susceptibility to unintended
12 consequences errors in accuracies?
13 But what are you going to do?
14 What are you planning to do in the future?
15 And I don't know whether that is appropriate
16 and it would just be a promise anyway. So I
17 don't know that it is going to be that
18 helpful.
19 So I just -- it's an interesting
20 discussion, but I don't know that as a
21 practical matter that it is going to require
22 us to change anything that is written in any

1 of the boxes.
2 CO-CHAIR LOTZ: Other than perhaps
3 adding a more future perspective, you know,
4 should any of these things occur, how do you
5 expect to handle them? Bill, go ahead.
6 DR. WILLIAM RICH: In just a
7 follow-up though, one of the concerns is is
8 that even when you have a poorly performing
9 measure, unfortunately, it takes about 18
10 months to fix it. And that's the other issue.
11 We have seen that with ACEs and
12 ARBs. I mean, there are a number of instances
13 now where you find something wrong, but them
14 programs continue with bad measures, because
15 it takes enough time to go through the
16 processes and then redo them. And it just
17 becomes -- would become part of the problem,
18 unfortunately.
19 CO-CHAIR LOTZ: All right. We are
20 up to a time when we can take a break. Before
21 doing that, closure on 4D and E?
22 DR. HALM: Second.

1 CO-CHAIR LOTZ: That's not really
2 how we are running this meeting. Stand as is?
3 All right. They stand as is.
4 How long of a break do you want to
5 give folks, Sally? We will come back. We
6 will talk about 5, which is the best in class.
7 And I know there was some desire on the part
8 of NQF to actually look at the call to measure
9 document, but I'm going to talk with Sally
10 about that on the break.
11 DR. NEEDLEMAN: Doris?
12 CO-CHAIR LOTZ: Yes?
13 DR. NEEDLEMAN: Somebody wanted to
14 go back to 4C.
15 CO-CHAIR LOTZ: Oh, sorry, Bill,
16 you did want to go back to 4C, briefly.
17 DR. WILLIAM RICH: Just a comment.
18 CO-CHAIR LOTZ: He is holding you
19 all hostage to your break, mind you.
20 DR. WILLIAM RICH: Thanks.
21 CO-CHAIR LOTZ: It's my job.
22 DR. WILLIAM RICH: If we do

1 eliminate all exclusions and, again, this is
2 an ongoing debate that are not electronic, you
3 get rid of all exclusions, because I don't --
4 you know, on the quality side, it's almost
5 impossible to capture and exclude a clinical
6 exclusion and, you know, administrative data.
7 CO-CHAIR LOTZ: All right. I
8 think the exclusion one can capture a little
9 more clearly about the administrative burden
10 that, you know, we can't have people chasing
11 down rabbit holes for every possible
12 exclusion.
13 I think that that clarity could be
14 added and it will probably address your issue,
15 Bill. All right. 15 minutes. Please, come
16 back at roughly 2:30. Thank you.
17 (Whereupon, at 2:16 p.m. the
18 above-entitled matter went off the record and
19 resumed at 2:33 p.m.)
20 MS. TURBYVILLE: If everyone could
21 start to make their way back to the seats,
22 that would be great. Thanks.

1 CO-CHAIR STEINWALD: All right.
2 Home stretch, folks. We will be done in X
3 minutes and Y minutes is the number of minutes
4 before we get started, so it's really X is Y
5 plus Y. Yes, and Y could -- all right.
6 Item 5, best in class. Now,
7 Ashlie, are you going to -- no, not on this.
8 You are waiting for the next item. Okay.
9 CO-CHAIR LOTZ: Excuse me.
10 CO-CHAIR STEINWALD: Yes, ma'am.
11 CO-CHAIR LOTZ: One brief
12 interruption. Jeff Rich said he was going to
13 try to join by phone, so I just wanted to see
14 if he is on, so that we can make sure we keep
15 him in the conversation. Would you just dial
16 and see if he made it on?
17 CO-CHAIR STEINWALD: Jeff, are you
18 on the phone?
19 MS. WILBON: Hello, Operator?
20 OPERATOR: Yes, ma'am?
21 MS. WILBON: Is that Jeff or is
22 that the Operator?

1 OPERATOR: This is the Operator.
2 MS. WILBON: Oh, okay. Is there
3 anyone who has dialed into the speaker line?
4 OPERATOR: Not at the moment,
5 besides the feed-line though.
6 MS. WILBON: Thank you.
7 CO-CHAIR LOTZ: All right.
8 CO-CHAIR STEINWALD: Yes, ma'am.
9 Item 5, best in class. And we may need a
10 little overall discussion about this
11 criterion, given that there are many, many,
12 many quality measures and very often they are
13 measuring the same thing. And this led NQF to
14 develop the best in class concept.
15 In resource measurement there may
16 be far fewer measures for a particular thing.
17 Ad so the broad issue on the table is do we
18 need to be concerned with that best in class
19 or is it something that we can decide to be
20 concerned with once we see what measures are
21 submitted? Any perspectives? Oh, yes, Ann?
22 MS. HENDRICH: At the risk of

1 creating a negative number with the formula
2 that you just laid out, I wondered, with the
3 group's permission, if I could add one comment
4 to the previous discussion before break?
5 And it was around 4C and D, in
6 that if there is a way that that measure could
7 consider if the proposed measure is taking
8 into account other measures so it is
9 collapsing or harmonizing other measures that
10 are in existence, but strengthening them in a
11 new way, so it is actually taking a measure
12 out of the field instead of adding more, I
13 think this should get bonus points.
14 CO-CHAIR STEINWALD: Bill?
15 DR. WILLIAM RICH: I guess I can
16 make a correction to my statement on 4C in
17 that using electronic means does not eliminate
18 all the exclusions. That was pointed out to
19 me by some of the staff.
20 CO-CHAIR STEINWALD: Okay. Paul?
21 DR. BARNETT: So moving on to 5.
22 CO-CHAIR STEINWALD: All right.

1 Well, are we good with -- is there a way to
2 accommodate what Ann said do you think?
3 MS. TURBYVILLE: Yes.
4 CO-CHAIR STEINWALD: Yes, okay.
5 We're good. Bonus points.
6 DR. BARNETT: So I'm a little bit
7 fuzzy about why the best in class is needed.
8 If I'm scoring 1 through 4, each of the
9 measures, and I give one higher and another
10 lower, aren't I done? Why do I need to do 5?
11 Because I have already compared, you know,
12 given them alternative scores and this just
13 seems redundant somehow.
14 CO-CHAIR STEINWALD: Sally, go
15 ahead.
16 MS. TURBYVILLE: It's in response
17 to the vast number of, in particular
18 currently, quality measures that users feel
19 are very similar and both will be endorsed and
20 it then presents to them some confusion about
21 which to use.
22 And so the idea is to help

1 eliminate some of the redundancy of the
2 quality measures, especially as they go
3 through maintenance. So if two measures are
4 found to meet all the four criteria, so they
5 have to meet all the four even before they get
6 evaluated, and they are slightly different,
7 but very, very similar, so in particular they
8 measure the same population, there may be two
9 diabetes care measures, is there one that is,
10 indeed, considered to be better?
11 And it would be a Steering
12 Committee exercise to rate them through the
13 criteria where one may be stronger and
14 scientific acceptability, as Helen's example,
15 another may be stronger in feasibility,
16 because the data or the algorithm is more
17 readily usable, that would be something for
18 the Steering Committee to consider.
19 First, considering whether or not
20 they are similar enough to even be evaluated
21 in this No. 5. And then second, are some of
22 them stronger than others? What has been

1 signaled to NQF, it is really important to the
2 users of these measures that we try to get a
3 handle on the repetitiveness of some of the
4 measures that are out there.
5 DR. BARNETT: So if I'm
6 understanding you right, then the first four
7 criteria, we just sort of -- it's a pass,
8 don't pass system. And then we get to 5 and
9 we start to weight some paths with higher
10 numbers than others and we begin to weight all
11 the criteria and decide which is best.
12 And so I appreciate that. It
13 makes some sense. But I would think it might
14 be important to engage and I don't know now or
15 maybe later, in some discussion about which --
16 are there some criteria that are more
17 important than others without having the
18 actual, you know, measures in front of us that
19 we are trying to evaluate, you know, do it a
20 priori.
21 Say, you know, which of these is
22 the most important to us? And maybe it's not

1 possible, but it does seem -- otherwise, you
2 know, if you leave that until later, then it
3 becomes a little bit more influenced by, you
4 know, the actual candidates.
5 CO-CHAIR STEINWALD: Lisa and then
6 Steve.
7 MS. GRABERT: I have a question
8 that I think pertains to best in class. I
9 don't know if it does. People can feel free
10 to comment on whether or not it does.
11 But if you put out a call for
12 measures for a specific resource use measure,
13 say, for example, diabetes and you have one
14 measure that is from an episode grouper, so
15 the product looks through all claims and
16 divides all claims into discrete episodes of
17 care. And in some cases, claims will be
18 competing against each other and may be put
19 into another episode over diabetes.
20 And then you have another measure
21 from a different developer that was only
22 specified for diabetes. Are you comparing

1 those two to each other for a best in class
2 type of scenario or are they apples and
3 oranges and you should not compare the two?
4 CO-CHAIR STEINWALD: Does anyone
5 have a perspective on that? Because I surely
6 don't. Ethan, you do. Are there others? All
7 right. Steve, then Bill, then Ethan.
8 MR. PHILLIPS: Well, I think my
9 comment is somewhat related to that. I mean,
10 I think I would anticipate that what we are
11 likely to end up with is a lot of overlap to
12 the extent that we get some of these kind of
13 broad systems that have developed and look at
14 a number of disease states.
15 And I think, you know, we may have
16 a challenge then with -- and may even want to
17 question -- you know, I would have a question
18 whether we want to just designate one best in
19 class, at that point. If they have all passed
20 the first four criteria, you know, there may
21 be some value in having multiple competing
22 systems out there that users can choose from.

1 CO-CHAIR STEINWALD: Bill?
2 DR. WILLIAM RICH: I don't think
3 the resource use measures are comparable to
4 the quality measures. With the quality
5 measures, we could evaluate, you know,
6 scientific validity, strength of literature,
7 presence or absence of exclusions.
8 With this, it's very different.
9 And I would be very reluctant for NQF to kind
10 of pick a winner out of something with so many
11 vagaries that happen with the implementation.
12 Again, looking at the current measures, it was
13 years before we found out the current
14 limitations in the McGlynn paper and the Cumin
15 papers.
16 I think we put ourselves at a
17 little risk of picking the best in class. Let
18 them meet the criteria. Get out there and if
19 there is problems, Allison said, you can
20 report back. Ashlie said you report back.
21 But we have to be very reluctant to give the
22 informator to a best in class with -- I think

1 it's very different than quality measure.
2 CO-CHAIR STEINWALD: Tom?
3 DR. ROSENTHAL: Yes, I was going
4 to say the same thing. But I was also going
5 to ask was this best in class concept part of
6 the very first quality --
7 MS. TURBYVILLE: No.
8 DR. ROSENTHAL: Well, it couldn't
9 have been, that's the whole point. So we are
10 where we were 8 or 10 years ago with the
11 quality thing and I don't think we should try
12 to superimpose what has been successfully
13 developed over what is effectively the outset
14 of another kind of metric. It adds on to the
15 comments that Rich just made.
16 CO-CHAIR STEINWALD: All right. I
17 have heard a number people say or imply that
18 we don't need and ought not to have a best in
19 class criterion. Is there anyone who would
20 like to argue the other side? Well, are you
21 up? Because you are up.
22 DR. HALM: No. I mean, I was just

1 going to say, you know, this is all about
2 timing. So really, this is really going to be
3 first in class. Anything that doesn't fail
4 and gets a passing grade is going to be best
5 in class from a timing perspective, so I don't
6 know that we can comment on it.
7 I don't have a problem down the
8 road with it as sort of an extra credit
9 tiebreaker kind of thing, because we may want
10 that. But right now, there is nothing. So
11 for the first round, it may not make sense to
12 have this for the first go-round. Unless we
13 want first in class to inherently be best in
14 class.
15 CO-CHAIR STEINWALD: Steve, I had
16 thought you were still up from before, but
17 maybe I was wrong. You were still up? Okay.
18 Dolores and then Barbara. Barbara and then
19 Dolores.
20 DR. RUDOLPH: You guys can go
21 first.
22 CO-CHAIR STEINWALD: Lisa?

1 MS. YANAGIHARA: Yes, I still
2 think though even though we are at the
3 beginning, if we get kind of multiple measures
4 around a particular topic, whether it is
5 diabetes or whatever, I don't know that we
6 want to endorse all of them that kind of meet
7 the criteria, because then when the same
8 situation that we were in with quality where--
9 how do you know which one to use, unless they
10 really are measuring different aspects of
11 care?
12 So even though it is the first go-
13 around, I still think there needs to be some
14 assessment for measures that are really kind
15 of focusing on the same areas, otherwise, I
16 don't know.
17 CO-CHAIR STEINWALD: Now, I've got
18 the order wrong. You know what it is.
19 CO-CHAIR LOTZ: Lisa, Barbara,
20 Jeff.
21 CO-CHAIR STEINWALD: Thank you.
22 CO-CHAIR LOTZ: Oh, and Joseph.

1 Sorry, Jack, you are after Joseph. Lisa?
2 MS. GRABERT: Generally, as a
3 concept overall as it applies to all measures,
4 I'm in favor of identifying best-in-class. I
5 think we have too many measures. And people
6 can't focus because we have too many measures.
7 And best-in-class sort of focuses and makes
8 people prioritize measures.
9 So in general, I'm in favor of the
10 overall concept. As it applies to resource
11 use, I think that if these are eventually
12 going to be used for public reporting for
13 ranking or comparing people as peers, if you
14 have multiple measures that are slightly
15 different, people are going to rank
16 differently.
17 And I don't know what that
18 communicates publicly, but it doesn't really
19 help when people are ranked in different ways
20 based on different methodologies.
21 CO-CHAIR STEINWALD: Barbara?
22 DR. RUDOLPH: I agree with

1 everyone. No.
2 MS. GRABERT: Okay. Joe?
3 DR. RUDOLPH: I guess my concern
4 about best-in-class for this is just our
5 capacity to actually make that decision, given
6 -- just seeing the kind of documentation that
7 was sent in on the 3M measures that, you know,
8 we are talking 500 or 600 pages of
9 documentation on the grouping capacity.
10 Are we really going to have the
11 time and wherewithal and energy to really make
12 a determination about some of these very
13 sophisticated products? I'm not sure. I
14 mean, I guess I would hate to pick one and
15 then later on find out that we really made a
16 bad decision, because we hadn't read every
17 single page and so forth.
18 It may be too soon to do this. I
19 just don't know.
20 CO-CHAIR STEINWALD: Tom and then
21 Jack. I'm sorry, Joe and then Jack.
22 CO-CHAIR LOTZ: Joe.

1 DR. STEPHANSKY: After suffering
2 many years of seeing every risk management
3 case coming across my desk at a hospital, I'm
4 kind of surprised that we don't have somebody
5 here from your legal department, because if we
6 end up having Thompson, Reuters and Ingenix
7 and 3M submitting similar measures, and we are
8 looking at the possibilities of big income
9 streams accruing to whoever wins, I'm not sure
10 we are going to want to -- or that NQF's legal
11 department will let you choose one of those.
12 CO-CHAIR STEINWALD: Boy, that
13 sounded ominous to me. (Laughter.)
14 DR. STEPHANSKY: Well, I don't
15 know.
16 CO-CHAIR STEINWALD: Jack?
17 MR. BOWHAN: To the extent that we
18 are looking at provider groups using these
19 measures, a group or a system may have one of
20 these products, Ingenix or Thompson. So okay,
21 we say best-in-class for diabetes is Ingenix.
22 Best-in-class for cardiovascular disease is

1 someone else and someone else.
2 Well, they could -- if -- I'm
3 thinking that if they meet the criteria 1
4 through 4, approve it. And to Bill Rich's
5 point, let's see how this plays out down the
6 road and, if something really sticks out as
7 better and -- maybe we're also back to the
8 discussion about public reporting with these
9 performance measures, especially just on
10 resource alone. Maybe we are still not quite
11 ready for that.
12 CO-CHAIR STEINWALD: Lisa, are you
13 still up? Okay.
14 MS. GRABERT: Yes. I have
15 something else to say.
16 CO-CHAIR STEINWALD: Okay.
17 MS. GRABERT: Thank you. I think,
18 too, that maybe the Subcommittee that will be
19 looking at the individual criteria might help
20 us out a little bit here, because questions
21 like attribution benchmarking are issues that
22 are policy-based that may be able to push you

1 for best-in-class on certain measures that do
2 address it, versus other measures that don't.
3 CO-CHAIR STEINWALD: A question
4 kind of for, I think, NQF. As I have heard
5 you describe the endorsement of measures,
6 there is this three-year life cycle, right?
7 You expect the developer or someone else to be
8 the steward of the measure and maintain it and
9 collect information about it, which kind of
10 leads me to the conclusion that you might need
11 that period before determining how good a
12 measure really is, and thereby implication of
13 whether it is best or not.
14 You know, the best one might be
15 the one that has the least number of
16 unintended consequences or misuses, something
17 that is hard to predict in advance. Any
18 reaction to that?
19 CO-CHAIR LOTZ: Yes.
20 CO-CHAIR STEINWALD: Go ahead.
21 CO-CHAIR LOTZ: For the most part,
22 my understanding is these measures aren't

1 coming in as brand new just-birthed measures.
2 Some of our requirements state to the measure
3 developers: include your pilot or your, you
4 know, prior use, as part of your submission
5 package.
6 So they should come in with some
7 body of experience that speaks to how good
8 they are at accomplishing what they want to
9 accomplish. The other question about legal --
10 and I wish Helen was here, and NQF staff
11 correct me and I'll try to represent what she
12 said late yesterday evening -- which is, NQF
13 has run into that before and they have dealt
14 with it.
15 And that's just part of the work
16 that they do. And yes, other measure
17 developers who have not successfully had their
18 measure endorsed have challenged NQF, and
19 that's part of the business that they do.
20 So that's not a deal breaker. If
21 Helen was here she may say it differently, but
22 that's what I understood she said yesterday.

1 CO-CHAIR STEINWALD: All right.
2 Joe and Jack, you are still up. No? Okay.
3 Then Barbara?
4 DR. RUDOLPH: I was just thinking
5 of another question that we should ask is:
6 how many successful lawsuits have been filed
7 against them for their rankings?
8 CO-CHAIR STEINWALD: Okay. So
9 there is some sentiment in favor of the best-
10 in-class concept. What if we stated it --
11 huh? Go ahead.
12 MS. TURBYVILLE: I guess I heard a
13 little bit of both.
14 CO-CHAIR STEINWALD: Well, that's
15 what I said.
16 MS. TURBYVILLE: Best-in-class,
17 oh, I see. I thought you said some sentiment
18 for. I kind of heard sentiment for and
19 against.
20 CO-CHAIR STEINWALD: Oh, yes, I
21 think there is more against than for, but
22 there are some for, that's my assessment.

1 What if the language were crafted such that:
2 NQF reserves the right, if multiple measures
3 are submitted that essentially are measuring
4 the same thing, to identify one measure as
5 best-in-class? Would that --
6 MS. TURBYVILLE: He wants to talk,
7 his card is up.
8 CO-CHAIR STEINWALD: Yes, go ahead.
9 DR. GOLDEN: I suggest you take a
10 quick poll of the room, because sometimes
11 silence you may interpret incorrectly.
12 Because I'm certainly very comfortable with
13 best-in-class, and I haven't said anything.
14 I'm just sitting here waiting for the next
15 item.
16 CO-CHAIR STEINWALD: Okay. Well,
17 it would be the -- I don't know, what would we
18 do? Let's say if it was a majority one way or
19 the other, is that what we would do -- have
20 majority rule? Tom?
21 DR. ROSENTHAL: Well, as somebody
22 who spoke out against the notion, I would

1 accept the language you proposed of: reserves
2 the right to, leaves it open to -- let's see
3 what we get. So as somebody -- without
4 subjecting the thing to a formal vote, I would
5 agree with that kind of language.
6 Leaving it as it is now, I would
7 vote against, because it really implies that
8 we are going to do that. And I really think
9 we are -- this is -- this didn't even exist as
10 an NQF criteria when the quality measure
11 started. And I continue to believe we can't
12 treat this like we treat the quality measure
13 world, because this is the infancy of it,
14 despite the fact that there may be a couple of
15 years worth of somewhat more private kind of
16 endeavors along those lines.
17 CO-CHAIR STEINWALD: Jeptha, then
18 Paul.
19 DR. CURTIS: Yes. I think it's on
20 the same lines, but I think what is
21 uncomfortable is if the expectation is that
22 you make that judgment, you be prepared to

1 make an absolute judgment.
2 CO-CHAIR STEINWALD: Yes.
3 DR. CURTIS: It may be in certain
4 circumstances that you can make that judgment
5 and you feel comfortable with it, or that the
6 Steering Committee feels comfortable with it
7 at the end of the day. But I think it just
8 needs to be clearer, is this expected that we
9 are choosing best-in-class or that we are
10 attempting to where possible? And I think
11 having that opt-out gives us enough leeway.
12 CO-CHAIR STEINWALD: Paul?
13 DR. BARNETT: Yes. I think the
14 where possible is good. I think since we are
15 having these five specific clinical areas that
16 are being addressed, it is not like we are
17 going to be rating the products, but rather
18 some little part of each product.
19 And then the other thing I would
20 say is, if we do want to go down this best-in-
21 class -- just to reiterate what I said at the
22 outset -- before we break the seal on the

1 package, on the submission package, we ought
2 to have our scoring algorithm together, to
3 have thought about what is most important that
4 we are going to use to judge.
5 So assuming we have measures that
6 meet all of the criteria in the minimum, then
7 which attributes -- how do we weight the
8 different attributes? Do we 1, 2, 3, 4
9 equally, or is there scientific -- get two
10 points -- or, you know, like that?
11 CO-CHAIR STEINWALD: How has NQF
12 done that in the past? Are all animals
13 created equal?
14 MS. WILBON: Yes. So there is
15 actually a hierarchy to the criteria. As
16 Helen mentioned earlier, importance is the
17 first one. You must meet the importance
18 criteria in order for the Committee to even
19 continue to review it.
20 And then -- actually the way or
21 the order that we have reviewed them today are
22 actually the order of the hierarchy. So

1 importance is first, scientific acceptability,
2 usability and then feasibility.
3 Each criteria is ranked and sub-
4 criteria is ranked on a met, I don't know each
5 of them, it's met, partially met, fully or
6 completely met or -- so there is actually --
7 CO-CHAIR LOTZ: Not met at all.
8 MS. WILBON: -- not met at all.
9 So even within the sub-criteria, there is a
10 range of how well the developer of the data
11 submitted for that particular criteria was
12 demonstrated. So there is a range of ratings
13 within that.
14 CO-CHAIR STEINWALD: Okay. Do you
15 have enough guidance to go on? If multiple
16 measures are submitted that are measuring the
17 same thing, NQF may identify one measure as
18 best-in-class, something like that?
19 MS. TURBYVILLE: I have enough to
20 take it back to the folks that are running the
21 Task Force and get their reactions.
22 CO-CHAIR STEINWALD: Okay.

1 MS. TURBYVILLE: So it may be
2 better to -- and then we will come back to
3 with further suggestions on how to handle
4 this. But have the different opinions and
5 some thoughts about potential language that
6 would be agreeable and we will go ahead and
7 work with that.
8 CO-CHAIR STEINWALD: Okay. Jeff,
9 your card is still up. Are you -- okay. I
10 think then we could be done with Item 5 and
11 therefore done with the criteria.
12 Next item on the agenda, Ashlie
13 will walk us through the call for measures.
14 MS. WILBON: So this document was
15 actually in the PDF packet. I'm not sure if
16 everyone has that on their computer. We are
17 actually -- have changed our approach slightly
18 to what we thought we might do for this during
19 the meeting.
20 But essentially, we just wanted to
21 kind of frame the document for you. Part of
22 the task of the Steering Committee is to help

1 inform the call for measures. This is the
2 first time that NQF is doing a call for
3 resource use measures, so our thought about
4 this is that it would be as specific as
5 possible, so that developers and users --
6 Steering Committee -- know what to submit and
7 that the Steering Committee is getting what
8 they are expecting to get from the developers.
9 So the call for measures usually
10 is the first thing that most developers will
11 be looking for, to see whether or not what
12 they have in their portfolio fits the scope of
13 the project.
14 So it's generally a one- to two-
15 page document. What I have up here on the
16 screen is a template. We are not necessarily
17 asking for your input -- we want you to be
18 familiar with what is in it. We have actually
19 added a section here that I have up on the
20 screen -- let me enlarge this -- called
21 Special Instructions.
22 And this is something that we have

1 added in -- that we will probably add in for
2 this particular call for measures, because it
3 is a little bit different. And the intent
4 being that a measure developer should be able
5 to pick this up and decide whether or not they
6 are going to submit their measures.
7 So the question for the Committee
8 would be: what information would you want or
9 would you think -- based on the discussions
10 you have had today -- need to be on here for
11 it to be clear to developers what they should
12 submit?
13 Is it, you know, the level of
14 analysis? Some of this input may come
15 actually, or a lot of it may actually come,
16 from the sub-work group that is -- oh, sorry,
17 I can enlarge it a little bit more. Sorry.
18 So some of this may actually come
19 from or a lot of it may actually come from the
20 Subcommittee that we are -- or the work group
21 that we are putting together that will
22 actually go through each of the measure

1 specification steps and decide which they
2 absolutely need to meet and which ones would
3 be nice to have.
4 And maybe those must-meets are
5 those that go in the call for measures, so
6 that developers know exactly the breadth of
7 data and information they will need to submit.
8 So we don't necessarily need detailed feedback
9 right now, but if you have any general ideas
10 about what you think should go in the document
11 in terms of informing the measure developers,
12 we're open.
13 CO-CHAIR STEINWALD: David?
14 DR. PENSON: Well, I mean, isn't
15 it -- basically all this information would be
16 in the measure submission form? I mean, they
17 are going to be able to look at it and see
18 what they have to and not, right?
19 MS. WILBON: So also in that
20 packet that we gave you is the measure
21 submission form that we currently use for
22 quality measures. And Sally and I -- we have

1 looked at the measure submission form and
2 have, at the outset, kind of decided that we
3 would, pretty much decided, we would need to
4 make at least some textual changes to that
5 form, but needed to kind of hear the
6 discussion of the Steering Committee today
7 about the criteria to really decide how much
8 that submission form would need to change.
9 I think we are leaning toward --
10 it is probably going to need to change quite
11 a bit. So we don't necessarily need the
12 Committee's feedback on the submission form
13 today, but we just wanted, again, for you guys
14 to be a little bit familiar with what there is
15 there.
16 But the idea being that the
17 submission form would actually mirror the
18 criteria in some way, so that they are able to
19 put their information in, in order to
20 demonstrate the criteria.
21 Sally wants to add something.
22 MS. TURBYVILLE: Yes. So in some

1 sense, this is before they go to the
2 submission form, so they don't bother filling
3 out the entire submission and submit their
4 measure, and they are not even in the scope of
5 the project.
6 So it's kind of giving a signal to
7 them: don't even bother submitting. Or,
8 please, do bother submitting. So it's to help
9 the measure developer navigate all the various
10 projects that NQF has, so they can figure out
11 what to submit where.
12 CO-CHAIR STEINWALD: A screener,
13 kind of.
14 MS. TURBYVILLE: Yes.
15 CO-CHAIR STEINWALD: Bill and then
16 Barbara.
17 DR. GOLDEN: I'll just echo the --
18 I'll just repeat the comment I made to Sally
19 earlier today. I think that given the
20 complexity and the newness of this, I would
21 suggest that there needs to be a two-page kind
22 of 30,000-foot-vision of what we are trying to

1 accomplish, or what -- a statement of the
2 issue. A statement of the vision of what we
3 are looking for down the road.
4 You know, where we are now, where
5 we want to be. And then reference, either --
6 with links to more detailed statements to
7 guide development of your submission, or to
8 assess what you have got.
9 So I think there needs to be an
10 orientation within some pointers to go to
11 these thick documents. If we try to summarize
12 this thick document into a two-page call for
13 measures, I think we are going to befuddle
14 people. I think we would be much better off
15 with a general sense of what we are trying to
16 accomplish.
17 CO-CHAIR STEINWALD: Barbara?
18 DR. RUDOLPH: I think I would --
19 if it were up to me, I would include the
20 principles and then serve that list of data
21 elements that the group is going to work on
22 and suggest that, if they are not capable of

1 responding to the appropriate ones, they
2 probably shouldn't bother submitting, because
3 I just don't think that they are going to make
4 it through, and it's just going to waste staff
5 time and their time submitting it.
6 CO-CHAIR STEINWALD: Mary Kay?
7 DR. O'NEILL: I guess I just feel
8 obliged to carry this message that I mentioned
9 earlier from the markets, which is that for
10 some quality organizations that are regionally
11 based, the application process is so onerous
12 and expensive that they can't participate,
13 even if they have experience on the ground.
14 And so -- maybe it's the intent of
15 the organization to not mess with the non-
16 usual set of suspects here in terms of measure
17 development. But thinking about what you are
18 looking for and helping people understand
19 whether or not they really do have something
20 valuable to offer to this process, I think
21 would be important.
22 And the Committee that is doing

1 the specifics under No. 2 may, after they do
2 that work, decide that only the big players
3 are likely to be eligible. But that, you
4 know, clarification around that and a
5 deliberate decision about that probably should
6 be made.
7 CO-CHAIR STEINWALD: Doris?
8 CO-CHAIR LOTZ: I want to take an
9 opportunity to echo that and say that, you
10 know, if we are starting a new project, more
11 or less, looking at resource use and contrast
12 to the quality that has been done, perhaps
13 this is an opportunity to look at that form.
14 Word on the street from the folks
15 that I travel with is that it is a bear.
16 Whether you are big or small, whether you have
17 resources or not, it is a user-unfriendly
18 document. And inasmuch as, you know, we are
19 starting a new project for NQF -- oh, and I
20 have given that feedback to folks here at NQF,
21 primarily Helen. People felt very grounded in
22 the document and it was, you know, put

1 together to meet a number of obligations and
2 could not really be changed.
3 All right. Well, now, we are
4 starting a new project here. Let's change the
5 document and try to be as, you know, user-
6 friendly as we can, so that we have a broad
7 catchment and people won't feel frightened off
8 and not submitting good measures, because,
9 again, the document is just so horrible to
10 navigate through.
11 CO-CHAIR STEINWALD: Yes. I hope
12 we can talk about user-friendliness and being
13 receptive to measure developers. Lisa?
14 MS. GRABERT: Yes. I think this
15 is maybe an area where CMS could provide some
16 good guidance on. I agree, a higher 30,000-
17 foot-level coming-out document would be very
18 helpful. If we are really talking about using
19 these for 2012, 2014 -- parameters that are
20 built into the legislation and they are going
21 to be used for that purpose -- if you don't
22 have the stomach or the appetite to be able to

1 defend your methodology to be used in those
2 kind of programs, you might not want to
3 participate in this process.
4 It's maybe a tough message that
5 needs to be sent.
6 CO-CHAIR STEINWALD: And
7 interpreting that, that is saying that, yes,
8 the process is onerous, but it is a necessity
9 in order to get measures that are going to be
10 up to the task of what you just mentioned that
11 is required in the law. Is that kind of it?
12 Okay. Mary Kay?
13 DR. O'NEILL: But that states that
14 the purpose of this whole effort is to get to
15 those measures for those purposes, and not a
16 broader purpose of resource utilization across
17 a variety of payers, right? I mean --
18 CO-CHAIR STEINWALD: Yes, yes.
19 DR. O'NEILL: -- and that's okay.
20 I mean, just it needs to be explicit.
21 CO-CHAIR STEINWALD: Well, I mean,
22 I think we have said all along we don't want -

1 - you know, we want to be forward-looking.
2 DR. O'NEILL: Yes.
3 CO-CHAIR STEINWALD: We expect our
4 health care system, and we hope, to go through
5 some evolution. We would like to have
6 measures that are -- even if they are not
7 ready for prime time now, they would be at a
8 time when we have got some real delivery
9 system innovations that need to be evaluated.
10 But then, can we accommodate both
11 needs simultaneously? There is an immediate
12 need for measures, especially for CMS. Then
13 there is the longer term need to meet the
14 needs of evolving health care systems. Can we
15 do both? Ethan?
16 DR. HALM: The way I under -- yes.
17 I'm going to suggest that, you know, we
18 probably need Helen in the room or on the call
19 when this discussion happens. I mean, sort of
20 some of this feels to me like the orphan-drug,
21 you know, kind of issue of what do you do when
22 you have got sort of smaller players who have

1 important value-added things, but just don't
2 have the resources of the big boys. And the
3 extent to which, you know, this is a policy
4 issue where NQF can sort of think about, you
5 know, ways of trying to accommodate or provide
6 technical assistance to some of these, you
7 know, smaller less well-resourced enterprises
8 that may have, you know, good intellectual
9 measures out there.
10 But I don't -- it sounds like this
11 probably relates to a bunch of different
12 things. And I'm not sure we're going to
13 resolve it, you know, today, but I think, you
14 know, besides the people that spoke up,
15 several other people at the discussion have
16 sort of talked about this.
17 And right now, there is a big
18 return-on-investment reality for a small
19 handful of companies, but we hope to have much
20 more than just what those companies are
21 producing, even if it may be quite useful for
22 what it is.

1 CO-CHAIR STEINWALD: One of the
2 things that NQF has asked us to consider is,
3 can we identify some potential measure
4 developers and submitters who are not in the
5 usual cast of characters?
6 Could we actually have a little
7 bit of an outreach program, where we might get
8 in touch with an organization that we know is
9 measuring resources, but has not typically
10 submitted for the kind of review that NQF
11 requires.
12 MS. TURBYVILLE: Just to parrot
13 what I have heard Helen say on numerous
14 occasions, that we invite and welcome and
15 expect and hope -- for the expectation of our
16 Steering Committee Members, if they know of a
17 measure that is related to the project that
18 they are sitting on to, please, reach out to
19 them.
20 And, you know, our call for
21 measures, our website, it's all public.
22 Anyone can get to it, but some of the smaller

1 measure developers may not realize that there
2 is an opportunity to submit. So we do,
3 indeed, want more than just the usual cast of
4 characters.
5 Clearly, we have heard on many
6 occasions, and having sat on the other side of
7 the table, how difficult it is to submit the
8 information through the measure submission
9 form, but it is also tied to a database which
10 is very complex.
11 So we certainly will work with you
12 to try and make it as simple as possible, but
13 we may be limited just by the infrastructure
14 of the IT system itself. It is web-based.
15 But we will, of course, continue to welcome
16 your input on that. But we are somewhat tied
17 to the resources that are available in that
18 infrastructure.
19 CO-CHAIR STEINWALD: Well, if we
20 were to let's say send you an email with names
21 of people in organizations, is that something
22 you could work with or would you need more

1 than that? That would be enough?
2 MS. TURBYVILLE: We would make
3 sure that they know that this is ongoing. And
4 for example, I have already spoken to a known
5 measure developer to myself; they have never
6 submitted a measure to NQF, so I kind of
7 talked to them about what we are and where our
8 website is. And so we are absolutely to the
9 extent that we can, making sure that they
10 understand that if they have a resource use
11 measure that they think will meet the
12 criteria, etcetera, we would welcome them to
13 submit them.
14 CO-CHAIR STEINWALD: Okay. Bill
15 and then Dolores and then Barbara.
16 DR. WILLIAM RICH: Well, I would
17 like to say to Ethan's point, do we have any
18 dedicated resources? I would hope this would
19 stimulate in high cost areas like CHF, you
20 know, someone who is very knowledgeable,
21 because there is a lot of work being done at
22 EHA, ACC and others.

1 Do we have any dedicated resources
2 to help people with the application process or
3 is that what you are saying we're kind of
4 maxed out staff-wise? Because I would like to
5 see innovation here, something different than
6 the big three come forward.
7 MS. TURBYVILLE: I think that's a
8 question for us to take back to the
9 Department. But what we have gotten so far
10 when we have suggested that we probably would
11 have to change the submission form is a strong
12 pushback to change it as little as possible.
13 Primarily because of the resources involved.
14 It is actually substantial change,
15 because it is tied to these IT
16 infrastructures. But we are trying to think
17 a little bit out of the box, since it's a new
18 effort. Can we accept some things through
19 email that would go into an Excel spreadsheet
20 and then figure out how to tie it to the IT
21 data set? We're just not sure.
22 So we are not shutting the door,

1 but we have to make sure we are keeping in our
2 IT folks and make sure that we have that
3 dialogue going appropriately so we don't make
4 false promises to all of you.
5 CO-CHAIR STEINWALD: Dolores and
6 then Barbara.
7 MS. TURBYVILLE: Just to --
8 MS. WILBON: Oh, I'm sorry, I just
9 want to piggyback --
10 CO-CHAIR STEINWALD: Yes, go ahead.
11 MS. WILBON: -- on Sally's
12 comment. I think maybe what I heard Bill
13 saying is, if a measure developer submits, do
14 we kind of help them through the process? So
15 the submission process on the quality side, my
16 experience is that a lot of times people don't
17 get it right on the first time.
18 So we do actually -- I'm not
19 advertising, obviously, that it's a part of
20 our, you know, operation, but we do help
21 developers through the process. And as much
22 as we want their measures in, we want to make

1 sure that they are -- and a lot of that is
2 with the Steering Committee, too.
3 We want to make sure that the
4 information you get is in the right place.
5 It's, you know, easy to read and easy to
6 reference. And so the staff does do a bit of
7 work on the front end. I think as Doris had
8 mentioned before, too, we actually do spend
9 time with the forms, with the developers
10 before they actually get to you to make sure
11 that they are the way they should be and ready
12 for review.
13 CO-CHAIR STEINWALD: Dolores and
14 Barbara.
15 MS. YANAGIHARA: Yes. I think we
16 have got a lot of real-life constraints with
17 criteria that need to be met and IT and
18 resources and all that kind of stuff, but we
19 also have a dilemma, because I think there are
20 more and more community coalitions who are
21 trying to do this kind of measurement, and
22 they are looking to NQF and NQF endorsed-

1 measures.

2 I mean, we really want to use NQF

3 endorsed-measures. And yet, if it is only the

4 measure developers who have something for sale

5 who are going to get endorsed because of the

6 process, you know, we're just not leaving a

7 lot of options.

8 I mean, we have got a set of

9 measures that we are using in California that

10 have been developed collaboratively and we

11 think they are good. We would love to submit

12 them, but I don't have the staff to submit it.

13 And so I don't know. I have already been

14 thinking about how do we get these measures

15 forward, so that others know that they exist,

16 that they can use them?

17 So anyway, it's just a bit of a

18 dilemma and I don't know what the answer is.

19 But it's just something to noodle on, I think.

20 CO-CHAIR STEINWALD: Barbara?

21 DR. RUDOLPH: Yes, a couple of

22 things. The submission is difficult, but the

1 rest of the process is also very difficult.
2 If your measure makes it through that initial
3 submission process, then, you know, if it has
4 got anything complex with it, you know, it's
5 going to go to at least one TAP, sometimes
6 more.
7 And it has been, at least, my
8 personal experience if the measure developer
9 isn't there to respond in person, it is highly
10 unlikely that that measure will end up making
11 it through. So you have got the expense of
12 also, you know, on somewhat short notice
13 making it to some of these meetings in person.
14 And I guess I was going to
15 recommend that perhaps someone could think
16 about like a mentoring process or something
17 where experienced measure developers who do
18 this, who come in and go through the process
19 a lot can actually get assigned to, you know,
20 a newbie coming through the process to help
21 prepare them for it, because it's really a
22 somewhat intimidating process.

1 Particularly if you have a measure
2 that is at all controversial, I mean, it
3 really is -- and the process goes on because
4 it is the TAP. It's the Steering Committee
5 meetings, then it's the CSAC, it's the public
6 comment period. You really need to, if you
7 have a measure going through, you need to have
8 your friends write in support of the measure.
9 I mean, there is just a lot of
10 work involved in getting a measure through the
11 process. So I don't know how we can improve
12 it, you know, but maybe there could be some
13 type of mentoring which helps in other kinds
14 of situations like this.
15 CO-CHAIR STEINWALD: Jack and then
16 Ethan?
17 DR. NEEDLEMAN: I guess two issues
18 I would put on the table. One, I am trying to
19 think about who is likely to be submitting.
20 You know, we talk about getting away from the
21 usual three. And in order to have a developed
22 measure, you have to have data and lots of it.

1 So there are only a limited number
2 of folks who are potentially in a position to
3 have been doing this work and submitting it.
4 The big three, obviously. Any insurer who has
5 opted not to contract with them to do this
6 kind of work but to develop it in-house and I
7 don't know who those folks are, but there are
8 folks around the table who should know them.
9 Integrated delivery systems, which
10 have the data and have chosen to develop this
11 kind of work in-house, and there are only a
12 limited number of those who could be doing the
13 work likewise.
14 Some of the state agencies that
15 have begun collecting all patient claims data,
16 including all the ambulatory claims might or
17 may not be doing this. They have the data and
18 again, they may well have been simply
19 contracting out.
20 So at that point, I exhaust myself
21 in terms of identifying who has enough data
22 and enough reason for doing this that they are

1 going to be doing it. And the big ones that
2 I think are missing from the consideration in
3 terms of being able to pull this out are
4 probably the integrated delivery systems,
5 which may have perfectly fine systems
6 internally and may or may not be interested in
7 making them public, making them public use in
8 any way.
9 So to the extent that the NQF
10 staff is looking for places that do this,
11 those are the usual suspects and those are the
12 places I would be looking and asking if people
13 have something they want to share.
14 The other thing is -- so that's
15 one thing. The same thing I have been looking
16 very quickly through the application form that
17 is in the materials. And it is written for a
18 certain kind of measure. And these measures
19 are different.
20 And I'm wondering whether it makes
21 sense to tell people, here is a narrative
22 outline that we would like to see filled in

1 that better tracks what the Committee will
2 want to look at and then go back from this and
3 kind of check the appropriate boxes and
4 reference the appropriate section in the
5 narrative outline for purposes of the
6 electronic form.
7 So I don't know that that will
8 work. I don't know if that should be the way
9 it is done, but it represents a way of solving
10 the crosswalk problem between we have got our
11 IT systems and the way they like to see us
12 present the data. And we have got a problem
13 of trying to read through a narrative
14 description of a measure so that we can
15 understand it and make sense of it in a
16 coordinated integrated way that may not match
17 what is in the application.
18 CO-CHAIR STEINWALD: Ethan and
19 then Bill.
20 DR. HALM: So one of the hats I
21 wear is as a researcher. So the solution to
22 most problems is just to throw money at them

1 and make people compete for those funds.
2 But from a policy perspective, we
3 have this like noncommercial developer issue
4 and I wonder if, you know, one mechanism is
5 through NQF through CMS to other folks who
6 have big incentives and seeing good resource
7 use measures developed is for people to think
8 about, you know, are a phase of grant funds
9 for people to, you know, develop measures or
10 if lots of these integrated delivery systems
11 have these measures, but it just doesn't
12 matter to them, that they don't want to --
13 it's not worth it to them to share the special
14 sauce unless there are some resources to help
15 them, you know, write or compete for some RFA
16 funds where one of the expectations is that
17 these will be submitted to NQF and made
18 publicly available.
19 CO-CHAIR STEINWALD: Right.
20 DR. HALM: I think if there is
21 some incentives for noncommercial folks to do
22 it, they might take them up on it. It's not

1 going to be guys around the table, you know,
2 taking $20s out of our wallet to make this
3 happen, but Niall wants to make this happen
4 and, you know, Karen Clancy and other folks
5 want to make this happen.
6 CO-CHAIR STEINWALD: And his wallet
7 is full of them in big denominations. I
8 wonder if the foundations that have some small
9 grant programs that could provide subsidies to
10 noncommercial developers? I mean, the
11 Commonwealth has, you know, been promoting
12 bending the cost curve and developing a more
13 efficient system.
14 And you would think that the
15 development of measures would be consistent
16 with their overall strategy, but maybe that's
17 something worth looking into. Bill? What
18 about --
19 DR. GOLDEN: Anybody would have
20 knocked it over.
21 CO-CHAIR STEINWALD: What about
22 LeapFrog Group and the employers and the --

1 CO-CHAIR LOTZ: I think some of
2 the big business groups have done some work on
3 quality improvement.
4 CO-CHAIR STEINWALD: Yes.
5 CO-CHAIR LOTZ: You know, Pacific
6 Business Group on Health and the Midwest
7 Business Group whose name is escaping me right
8 now, but I would put them on the list to, you
9 know, do calls out to and say we are putting
10 out a call for measure and do you have
11 anything you want to submit? They may have
12 the bandwidth to go through the process as
13 well.
14 DR. RUDOLPH: I can respond for
15 us. You know, we have taken a couple of
16 measures through the process and they are
17 coming up. They will be coming up shortly for
18 maintenance, and there is no way we have the
19 bandwidth to do anything in this area.
20 And I'm thinking about the other
21 groups. You know, potentially, you know, I
22 don't know, maybe possibly Pacific Business

1 Group on Health through CHART, but I don't
2 know. I don't know if they have any resource
3 use measures or not.
4 Yes, they are already using some
5 of our stuff. But most of the employers don't
6 have that kind of shop that they could do this
7 kind of work.
8 CO-CHAIR LOTZ: If that's the
9 case, then I think we need to go, briefly,
10 back to an earlier conversation that says then
11 the process by which a measure gets endorsed
12 is precluding some very thoughtful people and
13 needs to be seriously looked at.
14 Well, I'll leave it at that. We
15 said it already.
16 CO-CHAIR STEINWALD: Bill?
17 DR. GOLDEN: Yes, I'm sorry, I was
18 out of the room for a second. If you're
19 looking for possible people who are going to
20 submit, did you mention the Group Health
21 Collaborative up in Seattle?
22 CO-CHAIR STEINWALD: We mentioned

1 the --

2 DR. GOLDEN: They have a lot of --

3 they have a huge amount of combined data sets

4 with HMOs. And I imagine the former

5 McClellan's Group was the other one.

6 CO-CHAIR STEINWALD: McClellan.

7 DR. GOLDEN: Who has got all the

8 data sets and they are running a lot of

9 efficiency measures.

10 CO-CHAIR STEINWALD: Yes.

11 DR. GOLDEN: I think he is funded

12 by Commonwealth.

13 CO-CHAIR STEINWALD: Okay. Well,

14 I think the suggestion is for specific ideas

15 like that to send them to Sally and Ashlie

16 with contact information if you can. And they

17 have agreed to outreach a bit to see if we can

18 generate some interest, more interest. Mary

19 Kay?

20 DR. O'NEILL: Living in the shadow

21 of Group Health as I do, one of the problems

22 with their work has to do with difficulty in

1 generalizing their measures across types of
2 enterprises that aren't fully integrated HMOs.
3 CO-CHAIR STEINWALD: Yes.
4 DR. O'NEILL: And, I mean, that's
5 some of the limitation with the Kaiser data as
6 well, so it's very nice that they are doing
7 things very well internally. But you need to
8 take a look at what they even know about
9 themselves and how to apply it and it gets
10 pretty limited.
11 CO-CHAIR STEINWALD: Okay. We
12 also have public comment, too, which I think
13 we probably need to do.
14 MS. TURBYVILLE: Yes, at 3:25.
15 CO-CHAIR STEINWALD: All right.
16 Yes, soon.
17 MS. TURBYVILLE: Two minutes, yes.
18 CO-CHAIR STEINWALD: Does anybody
19 have a two minute comment? Actually, to
20 respond not so much about Group Health
21 Cooperative, but, in general, you know, the
22 forward-lookingness if, you know, we are going

1 -- we are hoping to have more integrated
2 delivery systems in this country.
3 And they may all look different
4 from one another and we can acknowledge that.
5 But for my money, if we got a measure that was
6 developed and it was tested only in one, but
7 if it's the kind of organization that we want
8 to see more of and we are hoping to see more
9 of in this country, then I wouldn't exclude
10 it. I would be more accepting of that kind of
11 measure for the future.
12 Jack, you had something?
13 DR. NEEDLEMAN: Yes. Just as I
14 was trying to catalog who might have a measure
15 and the data to do it, the one group I
16 realized I left out was Prometheus, which had
17 $6 or $8 million in grant funds from various
18 sources to go develop something.
19 And so my question is, does
20 anybody know of anybody else like Prometheus
21 that is outside of the standard development
22 thing that also should be on the list of folks

1 to be in touch with?
2 CO-CHAIR STEINWALD: David?
3 DR. REDFEARN: I just was walking
4 over to the restroom and thought, have you
5 talked to the Association, Blue Cross/Blue
6 Shield Association? You know, there was an
7 initiative in the Association that has been
8 going for several years called the Blue Health
9 Initiative, BHI. It is a consolidation of
10 databases from a lot of individual Blue Cross/
11 Blue Shield plans.
12 I think it has been -- well, I
13 think it had both quality and cost measurement
14 goals. I don't know the status of -- I know
15 it is going. I don't know the specific
16 status, because WellPoint pulled out. We
17 didn't see any -- we were paying tons of money
18 and we didn't see the value, so we pulled out.
19 So I don't know what the current status is.
20 And of course, the way the
21 Association works is that the Association
22 doesn't do anything, but they coerce the

1 participating plans to do something, but
2 that's the way to get some of the blues
3 involved in this, too, if you wanted to try
4 it.
5 MS. TURBYVILLE: So just to kind
6 of give you -- and that is helpful. Thank
7 you. The folks that we have spoken to so far
8 include ABMS, who they develop their measures
9 as part of a grant. There was NCQA, Ingenix,
10 Thompson, Reuters, Cave Consulting and
11 Prometheus.
12 And so we have reached out to them
13 and actually spoken to them on the phone
14 already to make sure they know this is coming,
15 getting their inputs along the way,
16 encouraging them to look out for the White
17 Paper, to provide public comment, etcetera.
18 But what we know is we could
19 easily miss some others that you are all aware
20 of.
21 DR. O'NEILL: Does Milliman
22 generally participate in that? They are the

1 data holders for most of our original data?

2 CO-CHAIR STEINWALD: Milliman or

3 Mercer maybe?

4 DR. O'NEILL: Milliman has all the

5 state data for Washington and Oregon pretty

6 much.

7 CO-CHAIR STEINWALD: Do we need to

8 go to public comment?

9 DR. GOLDEN: Yes, the other group

10 to look into would be something like some of

11 the management associations like MGMA. Some

12 of them, there is an ambulatory surgery center

13 group, they may have some metrics that they

14 have been supplying to their members, that

15 could be useful.

16 CO-CHAIR STEINWALD: Okay. I

17 think we need to go to public comment and then

18 we can come back and wrap-up.

19 MS. TURBYVILLE: Operator, if you

20 could open up the line for the audience and

21 provide them the opportunity to ask any

22 questions or give comments to the Steering

1 Committee at this time?
2 OPERATOR: Absolutely. If you
3 would like to signal for a question or make a
4 comment, it's star 1 on your telephone keypad,
5 at this time. Using the speakerphone, please,
6 make sure your mute button is off or you can
7 pick up the handset. Once again, that is star
8 1 for questions or comments, at this time.
9 Our first caller. Caller, your
10 line is open when you hear the voice prompt.
11 DR. MUNLEY GALLAGHER: This is
12 Rita Munley Gallagher from the American Nurses
13 Association. May I comment?
14 MS. TURBYVILLE: Please.
15 DR. MUNLEY GALLAGHER: Thank you
16 once again for the opportunity to listen to
17 your deliberations. And I would really like
18 to reaffirm the comments that have been made
19 by Members of the Steering Committee regarding
20 the onerous nature of the current submission
21 forms.
22 That being said, while I do at

1 least conceptually appreciate the differing
2 nature of the resource use measures from
3 quality measures, I would respectfully suggest
4 that having two vastly different forms may
5 further serve to stifle measure developers in
6 their decision making as to submitting.
7 Finally, I would like to reiterate
8 the comment I made yesterday. Preparation of
9 the reviewers to evaluate the measures is
10 critical. Thank you.
11 OPERATOR: Once again, it's star 1
12 for comments or questions at this time, star
13 1. And it would appear that we have no
14 further comments or questions on the phone at
15 this time.
16 CO-CHAIR STEINWALD: Thanks.
17 MS. TURBYVILLE: Thank you.
18 CO-CHAIR STEINWALD: All right.
19 So now should we turn it over to you to talk
20 about next steps?
21 MS. TURBYVILLE: Well, Ashlie, did
22 you get -- do you know what you need for --

1 MS. WILBON: Yes. I think we are
2 fine on the call for measures. I think what
3 is really going to drive a lot of this is the
4 work of the sub-group and we will revisit it
5 once that sub-group has had an opportunity to
6 meet and we will take what we can from that.
7 And then we will resend it out along with the
8 other materials that will need the final
9 review of the Committee and we will go from
10 there if we need any additional input. Thank
11 you.
12 CO-CHAIR STEINWALD: Sally and
13 Ashlie, do you want to take us through the
14 wrap-up?
15 MS. TURBYVILLE: So I won't spend
16 too much time, but hopefully just enough on
17 the next steps. Thank you, first of all, the
18 comments, deliberations, suggestions have been
19 really right on, very helpful. I think we are
20 going to be able to clearly improve the White
21 Paper, get the evaluation criteria so that it
22 is more on target and keep this project moving

1 forward. So it is really exciting for us to
2 have this momentum and continue it going
3 forward.
4 I'm going to look at the agenda
5 really quickly, just to make sure I don't
6 forget anything.
7 For the White Paper, I think we
8 have enough comments to improve it. However,
9 I know a lot of you are holding onto your
10 written comments. We absolutely must have
11 them by early next week. I'll give you until
12 Tuesday.
13 This White Paper, because it's
14 going to be posted to public comment in the
15 end of September, means that -- end of August,
16 I'm sorry, means that we have to be completely
17 done writing with it and get your kind of
18 final yes, this is good enough for public
19 comment within two weeks because it needs to
20 go to our Publications Department where they
21 do an extensive formatting, review, make sure
22 that we aren't tripping over ourselves or

1 anything of that nature. And they need at
2 least two weeks for a 50 page document.
3 So absolutely must have those
4 written comments to us by Tuesday or we are
5 just going to move forward with what we have.
6 And then there is other
7 opportunities in the future, you will get to
8 review the public comment of the White Paper,
9 once that is done, and another opportunity to
10 improve it once again before it is finalized
11 at the end of the year.
12 For the evaluation criteria, it is
13 slightly on a different time line though they
14 are important to each other clearly, but we
15 want the -- we have about an extra two weeks
16 with the evaluation criteria, which is
17 perfect, because we will be meeting with the
18 subgroup to finalize that criteria over the
19 next two to three weeks.
20 NQF staff will staff that sub-
21 group, so we will be emailing all of you who
22 volunteered in the next couple of days to

1 start setting up times where we can meet. I
2 imagine we will probably have to do maybe at
3 least two phone calls and we will see about
4 the third, so that we can make what is pretty
5 much a final recommendation to the Steering
6 Committee. Four? Is that a four? No.
7 Three. Do I hear four? Is this an auction
8 situation?
9 And so we will be working with
10 them to get that finalized and get that back
11 in front of you, I would say, at the end of
12 August. Am I getting it right? So White
13 Paper will be mid -- I was going to say mid-
14 July, but it is mid-July. End of July for
15 your final review and then the evaluation
16 criteria about two weeks later.
17 The pressing deadline for the
18 evaluation criteria, and all of you stated
19 this independently as a group yesterday is, it
20 must be complete and ready for scrutiny by the
21 measure developers before we do the call for
22 measures. And we are pretty committed to

1 doing this call for measures in September.
2 It is already I think a year off
3 in its initial conception of when it was going
4 to happen, so that has to be done and ready
5 for prime time and we will be working with you
6 to meet all those deadlines.
7 And the call for measures also
8 will be further informed by the sub-group and
9 we will get that in front of you as well in
10 short order. Yes.
11 So I don't have any exact dates
12 right now. We will go back in the email, kind
13 of reconvening the next steps for all of you
14 so you have it in hand and for those who had
15 to leave early, so that they know what is
16 going on, we will include some exact dates or
17 at least the date span, so that you have some
18 sense of what is to come.
19 And I think that is it. We have a
20 few items to make sure we communicate back
21 with our staff as they are comments that
22 really target broad processes at NQF. T that

1 includes the submission form itself and how
2 onerous it is and the implications that were
3 discussed here about that.
4 We will be sure to communicate
5 that and do what we can to make our submission
6 form as usable, friendly in a manner as
7 possible. But as you know, we will be
8 constrained a little bit, but we will push
9 that as hard as we can on your behalf.
10 And then the best in class, we
11 will take that back. Again, that's one of
12 those things that has some effect on other
13 Steering Committees, see if we can make an
14 exception here, figure out exactly how much we
15 can tinker with that. Because that would be
16 a little bit different than what we have done,
17 where we have been adding and expanding sub-
18 criteria.
19 So I'm glad to push that forward
20 on your behalf and we will get back to all of
21 you for your further reaction as well.
22 And I think that's it for next

1 steps. Getting you the White Paper. Getting
2 your comments to us if you have written,
3 getting that White Paper back to you, getting
4 it ready for public comment and wrapping up
5 that evaluation criteria and call for
6 measures.
7 And we are on that fast train. If
8 you thought it was fast before, it just is a
9 bullet train at this point. So any questions?
10 CO-CHAIR STEINWALD: Thank you,
11 Ashlie and thank you, Sally. This is very
12 hard work.
13 MS. TURBYVILLE: And Jennifer and
14 Maisha, critical to our team.
15 CO-CHAIR STEINWALD: Okay. And
16 Jennifer and Maisha.
17 (Applause)
18 CO-CHAIR STEINWALD: Yes, thank
19 you. A round of applause. Keep up the good
20 work.
21 (Whereupon, the Steering Committee
22 meeting was concluded at 3:35 p.m.)

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