**NATIONAL QUALITY FORUM**

**Moderator: Endocrine Standing Committee**
**January 28, 2015**
**3:00 p.m. ET**

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

Katie Streeter: Hi, good afternoon everybody, welcome to the Endocrine Cycle 3, Measure, Review, and Evaluation Webinar part two. Thanks for your patience. Today, we are still waiting for some committee members to be joining the call and in the webinar. If you are on the call, as (Bridgette), our operator stated, please make sure that you do log in to the webinar to make sure that you can be voting today. We do need to have enough committee members voting in order to meet quorum.

With that said, I'll take a quick roll call. And I know we have our co-chairs, Bill Golden and James Rosenzweig is on the line.

Is Robert Bailey on the line?

Robert Bailey: Yes, I'm here, thanks.

Katie Streeter: Great. Tracey Breen.

Tracey Breen: I'm here. Thank you.

Katie Streeter: Bill Curry?

William Curry: I am. Thank you.

Katie Streeter: Vicky Ducworth. James Dudl. Ingrid Duva. Starlin Haydon-Greatting.

Starlin Haydon-Greatting: Here.

Katie Streeter: Ann Kearns.

Ann Kearns: I'm here.

Katie Streeter: Sue Kirkman.

Sue Kirkman: I'm here.

Katie Streeter: Anne Leddy. Grace Lee. Laura Makaroff

Laura Makaroff: I'm here. Thank you.

Katie Streeter: Anna McCollister-Slipp.

Anna McCollister-Slipp: I'm here.

Katie Streeter: Patricia McDermott.

Patricia McDermott: I'm here.

Katie Streeter: Janice Miller. Claudia Shwide-Slavin.

Claudia Shwide-Slavin: Here.

Katie Streeter: Janet Sullivan. Bill Taylor. OK. I still believe that there are more on the line. Let's see.

Karen Johnson: Sorry, were trying to figure out who's on the line and who's who is actually calling on the webinar.

Male: I've got an e-mail that Anna McCollister is on hold somewhere.

Katie Streeter: OK.

Male: Will she join us?

Anna McCollister-Slipp: Yes, I'm here.

(Crosstalk)

Katie Streeter: I'm wondering some people were on mute when you're calling the roll.

Karen Johnson: That's what I'm thinking because I think more people are actually on than …

(Crosstalk)

Karen Johnson: … the ones that you didn't get a response from again.

(Off-Mike)

Katie Streeter: Is Vicky Ducworth with us? James Dudl.

James Dudl: Yes, can you hear me?

Katie Streeter: Hello. Thank you.

James Dudl: OK.

Katie Streeter: Ingrid Duva. Grace Lee. Janice Miller. Janet Sullivan. Bill Taylor.

William Taylor: I'm here again.

Katie Streeter: Hi there. Oh, sorry. Didn't see you the first time.

William Taylor: It's OK.

Katie Streeter: OK. So, we'll be jumping right in here to resume our conversation. The discussion on measure 0729, the Optimal Diabetes Care Measure Composite Measure. The committee did vote on all of the criteria needed for the importance to measure and report. And with that, I'll turn it over to the chairs if you would like to have any remarks about last meeting. And then we can jump back into the discussion for today.

Male: Well, I think everything work very well that time. And we're pretty, you know, roll in to the second measure. So, I think we, you know – I don't see why we shouldn't just start where we take off where we started last …

(Off-Mike)

Sue Kirkman: If I can. I would just like to remind everyone that is on the phone if you are listening to the event by your telephone line, please make sure your computer speakers are down or off to reduce the feedback and echo.

Male: Is something wrong with my line because I did mute speakers on the computer. How's that? It's OK.

Katie Streeter: Yes, it's OK from our end here.

Katie Streeter: Yes.

Katie Streeter: Also just quickly, I like to pause and make sure that we have our measure developers is only the line from Minnesota.

Collette Pitzen: Good afternoon, Collette Pitzen and Jasmine Larson from Minnesota Community Measurement are here.

Katie Streeter: Hi, welcome. Thanks.

OK. So, Karen, did you have any other remarks before we ask our lead discussants to jump back in?

Karen Johnson: We've already mention, as Katie mentioned, we did go through the criteria for this measure report. So, we're going to start out now thinking about the reliability sub-criterion. And I know at the end of the call last time, we started going a little bit into the risk adjustment stuff on this measure. And I know folks here in Minnesota started explaining things. So, I think we'll probably have some more questions for them on that. But perhaps, we'll go ahead with our lead discussant to just go ahead and start the discussion with the specifications and the reliability testing for this measure.

And that would be – who's our lead discussant?

Katie Streeter: Sue Kirkman.

Karen Johnson: Sue – oh, go ahead.

Sue Kirkman: Oh, I thought you were asking me something.

Karen Johnson: Do you want to go ahead and talk about what you found in terms of reliability and specifically specifications and the testing? Then we'll just go ahead and start the discussion there?

Sue Kirkman: OK. This is Sue. Do you want me to take lead or so …

Bill Curry: I don't mind to go ahead. I can start.

So, this is a composite measure as we remember talking about glycemic control, hypertension control, statin use, the patient being tobacco free and use of daily aspirin or antiplatelet. It's a composite measure that's collected to provider level and aggregated to the practice level for reporting. It is an all or none measure. And we have to meet all of the measures to have a successful pass on the composite.

Each of the components are very well-defined. They have, I think, done a thoughtful job with adjusting to the recent lipid management recommendations. And they have provided a very nice algorithm on how to decide if a patient is in need of statin therapy. And it's age-based and also so there is some dependence on an LDL if it's very high. But I think that they've done a very nice job with bringing that out.

So, I think all the elements are easily measured without confusion. All of the element should be easily collected from an EHR. They talk about practices that have had opportunities to collect the data manually because of difficulty with their EHR or lack of EHR. And there's been some challenges with that. But, I think that as we're all moving toward a digital world, this should be a pretty easy set of data to collect.

So, the only concern that I had mentioned before was the issue of the patients being tobacco free. And is that – did that made face validity criteria in terms of one of the components, and we had a small discussion about that and I don't

think there was a whole lot of issue about that. So, from the specifications, I think it's pretty straight forward and easily able to collect the data.

Karen Johnson: OK, thank you. So, Bill and Jim, you guys want to go ahead and just lead the group in any discussion about the specifications. And I guess with that said, I did have one question I did want to verify with the developers that the risk adjustment model. And we'll talk about it a little bit more under reliability but I just want to make sure that I understand correctly that the risk model includes age group, insurance product, and diabetes type. And those are the three factors that are being used in a risk adjustment model.

William Golden: Can you say that to me again, I'm sorry.

Karen Johnson: Age group, insurance product, and diabetes type. That's why …

(Crosstalk)

Sue Kirkman: Community measurement, that is correct.

Katie Streeter: That is correct, thank you.

William Golden: So, let's – so, we need to do the risk adjustment, let's say Medicaid versus Blue Cross, you would calculate them separately or you just get an adjust for being say on Medicaid versus Blue Cross?

Female: Is – Medicaid commercial and Medicare.

William Golden: No, I'm just – but at a separate silos or do you just draw a factor adjustment?

Female: It's a factor adjustment not stratification.

William Golden: OK. Floor is open.

Sue Kirkman: Hello, this is Sue Kirkman. I guess I'm still a little bit lost on where we finished last week and where we are now because it seems like we're talking about reliability but there was also some validity discussion. How far did we get into voting last week?

Karen Johnson: So, last week, we got through all of the first four sub-criteria under importance to measure a report. So, we are starting now with reliability. And under reliability, it's, you know, can the specifications be applied efficiently and what do the testing looks like for reliability.

You're right, we did delve into a little bit last time on some of the validity questions to kick early among the risk adjustment model. So – that's what's a little tricky. We talked about the risk adjustment model just a little bit because we're talking about (fix) under reliability. But we'll talk about it even more under validity.

Sue Kirkman: OK.

Karen Johnson: So, yes. I know it's …

Sue Kirkman: Yes, I mean the only thing I wanted to ask was that, you know, they do show reliability testing and, you know, which is – has a very high signal than to noise ratio, although there are some groups that are below the 0.7 threshold.

Karen Johnson: Yes. So, you know, in leading this submission, this is Karen again and I'll just go ahead and ask you because I was a little confused and I want to make sure when we write up the report and everything that I understand that you gave information about – the measure specified I think for clinician group. But some of that testing data that you provided was for clinics. So, can you just explain – let me make sure I understand completely who this is specified for? That might be a little different than how you report it, you know, in Minnesota perhaps.

But also, I want to make sure that I understand because in some of the information you presented for reliability, you presented it only for clinics that had at least study patients. And I am not completely clear if you're saying that this measure is specified only for those providers who had at least 30 patients. But can you just help me understand those things a little bit better?

Jasmine Larson: Sure. This is Jasmine. So, the measure specifies reporting as a clinic in medical group level, not in individual provider level. And multiple clinics may constitute a medical group. In regards to the minimum volume of

patients, we do not specify the measure to require a minimum of 30 patients. But that is how we to choose to report the information in Minnesota.

Karen Johnson: OK. Thank you.

Male: So, a question for the developer. So – or the steward because I don't think they developed this, but to the steward. You talked about the beta-binomial methods that you used to do the reliability testing. But when you look at the author that had developed a methodology, he talks about – it's more complex to do it for a composite measure.

And in the document, I think that that was provided for the reference for Dr. Adams, it really didn't go into detail on how to do the beta-binomial for a composite measure. So, was your technique to use the beta-binomial for each of the individual pieces of the composite or did you do a calculation based on the composite – all the pieces of the composite?

Jasmine Larson: This is Jasmine. So, my understanding of that paper by Adams is that when he discusses composite measure testing and reliability, I don't believe that he is including all their non-composites which are inherently binary. Instead, he's looking at composites that have weighted components. And it is our statistician's approach to continue use the beta-binomial method for reliability testing since it – composite construct of this type is built strictly binary.

Male: OK, so it's tested as a composite then?

Jasmine Larson: Yes.

Male: OK, thank you.

Male: No additional comments so we are ready I think to vote.

Female: Yes, I think so.

Male: Why don't you throw the voting slide up and – to give people last chance to consider a question or comment?

Anna McCollister: This is Anna. Are we voting on overall measure or we're voting on specific element of it? And then what else you can think …

Male: We're still in the elements. We were in the middle of the review, so that's why we'll get the slide up slide up and that will orient you a little bit.

Anna McCollister: OK, thank you.

Karen Johnson: And Kaitlynn is bringing up the slide now because we're starting in the middle. It's taking awhile to find it.

OK. Kaitlynn, you want to read this out?

Kaitlynn Robinson-Ector: Sure. Voting is open. Voting on reliability for measure 0729.

Male: And before – I guess, one question I have. Does the reliability include the risk adjustment or just the data extraction?

Female: Really just the data itself. We'll talk more about the risk adjustment model and the appropriateness of that under validity.

Male: OK, great.

Female: And I do believe we have 15 members voting. So we'll hopefully wait until we get that set number, we have 12 now. And oh, 15.

OK.

So the measure passes reliability and we'll move on to validity. Kaitlynn, do you want read out the votes?

Kaitlynn Robinson-Ector: Sure. Nine voted high, seven voted moderate, zero voted low and zero voted inefficient.

Female: OK. (Jim), you want to talk about validity? Or actually I think it was (Bill). I'm sorry, (Bill). I don't have …

William Golden: Well OK. I know. I get the question is if you had concerns about the risk adjustment, it would come into your vote and on validity. That's all.

James Rosenzweig: Yes. So for validity, I think there were couple of things that were done. So, one of the things that they accomplished was looking at this composite measure with another composite measure in the same study population and that measure was for vascular care.

And I think their thought was that if the two were fairly well-correlated that there would be an assumption of validity in this measure. So when the compare the same population with diabetes composite with the composite for vascular care, the correlation coefficient was 0.64 which they thought was reasonable.

So and I think that's a fair assessment. So in comparing the same population, the same practices to a separate composite, they have some pretty good correlation.

And then the other piece that they did, they looked at the issues of the risks adjustment. And they show in their work that with and without risk adjustment, there was still pretty good concordance in the scoring for the measure as a whole.

They broke it down into well-performing practices and not so well-performing practices, and across that continuum, they showed that the majority of practices actually stayed at the same rank if you will, for where they were. There were a few – some practices that would have scored better with the risk assessment. There were some practices that would have scored worst with the risk assessment or risk adjustment. But overall, it was pretty much a constant through the continuum of how well the practices were ranked in terms of their performance on the measure.

So, I assume – and the measure steward can help us out here that they only kept three of the risks adjustment parameters because the others that had been considered were not statistically significant.

Female: That is correct.

James Rosenzweig: OK. All right.

William Golden: So when you give the – when you test the risk adjustment on this process, what kind of practice sites were included? Was there any diversity in the practice site?

Female: It's all of those document data for us. So, all clinics in the state of Minnesota.

William Taylor: This is Bill Taylor. Would it be possible on the measure of validity stating there's good correlation with vascular care? Can you help me understand why that R square 0.64 means that is a valid measure for the diabetes measure, composite measure?

Sue Kirkman: So this is Sue Kirkman. My understanding is that just showing that high quality on this measure correlates with high quality on a different measure. So that you're sort of measuring – it sort of makes sense that if you have pretty good quality on this measure, you would have pretty good measure on other quality measures.

William Taylor: Right. So it's sort of might make sense but that's certainly not a strong evidence that it's a valid measure, right?

Sue Kirkman: Well, I mean, an R square of 0.64 is pretty decent, you …

William Taylor: It correlates quite well with it but to use that as (avenue) – to say that this is a good measure of quality in diabetes because it correlates with another measure of vascular care, doesn't really tell us much about the – or unless I'm missing something about the validity if this is a measure of diabetes care. I mean, it fits. Yes, you would expect that but that does – that's all, right? That's about as far as it goes.

Sue Kirkman: Yes. I guess, to me it sort of is this a good measure of quality and you would assume that practices probably have, you know, high or medium or low quality on average across multiple measures, and I would guess too that the vascular composite has some similar elements like it probably does have statins and blood pressure but maybe the developer can enlighten us.

Jasmine Larson: Yes, this is Jasmine. I'd be happy to talk to this.

So the correlation between the optimal vascular care and the optimal diabetes care measure is just addressing one component of validity, the face validity. And the rationale behind drawing a connection between the two is the requirement for ongoing management of a chronic disease that have multiple risk factors.

And, yes, they're – the composite of optimal vascular care is very similar to the construct of the diabetes care measure, and that, it looks at achieving a blood pressure target, cholesterol management, tobacco use as well as an aspirin antiplatelet component.

But I do want to clarify that they are different patient populations. And so they aren't the same measurements for the same patients.

Karen Johnson: And this is Karen. I will also clarify. You know, when it comes to dealing validation studies for measures of these types, you know, there's really – there's not a rule on what developer's ought to be doing.

So, one of the message that we accept at NQF is what they've done. It's really – I would actually classify this more than a face validity kind of when you're thinking about it. And I would actually characterize it as construct validity. And it's exactly as Sue was saying, you know, they've hypothesize that providers who are doing well with vascular care, also, potentially, are doing well with diabetes care.

So, that's their hypothesis, and they tested it in a way by looking at the correlation and found that basically the quality seems to be tracking. You know, there are others way or other things that they might have tested. They could have thought about, you know, other measures to correlate with. You know, they may have looked if they had the data, they may have said, hey, you know, if you're doing really well in your diabetes care, you have fewer amputations for example, or something like that.

They didn't choose to do that kind of testing, they could have. But, you know, we don't require a lot of testing. You know, another way that they potentially could have looked at things is – I think it's called known groups or something like that.

They could have said something on the order of, you know, we know that there are certain centers of excellence. And the centers of excellence have – tend to have higher scores on this measures than those who aren't. That's another way of doing validity testing in this construct validity way.

So again, lots of different ways they could have done it. We only ask, you know, that they do one and they've done this as four level. So, in terms of their methodology, you know, it is appropriate. And you guys would just have to consider, you know, do you buy the hypothesis that they put forward and are you happy with the level of results in terms of the correlation that they found.

William Taylor: Hey, it's Bill Taylor again. Now that I understand it a little better, it sounds like it's almost a better measure of reliability than it is a validity, right? Did one measure that looked at statins and blood pressure and tobacco correlate with another measure that looked at statins in blood pressure and tobacco, and the answer is yes.

Female: Yes. Reliability is really thinking a little bit more about being able to distinguish providers. But reliability and validity are very linked, so you're right in that way. And I think you're thinking about reliability in a way of consistency, and thinking about consistency as well.

William Taylor: Yes. Validity, the way I understand is more – is this really measuring the quality of diabetes care?

Female: Right.

William Taylor: Rather than consistency. Yes.

Female: Yes.

Female: So, this is …

(Crosstalk)

Female: I have question – for the developer, I guess. Unless you have talked about it and I missed it. But how do I understand the validity of this composite measure in terms of it being a composite measure of diabetes care versus discriminating against individual – the individual measures. I can't find that address and if it's in there. I would like it pointed out.

Female: I'll just guess. I'll try to address your question. As far as the evidence that the components identified in total impact positive outcome but I think that's more into the importance to measure criteria, and it's demonstrated in our composite constructs that maybe someone from NQF stuff can provide more information or clarity.

Female: Right.

Male: (Inaudible) isn't the NQF moving toward more composite measures or as individual measures?

Female: You know, I think in general, the field is thinking that that's the way to go. NQF hasn't really comedown and said, you know, we much rather see a composite than much of individual measures. In some cases, yes. In some cases, they haven't said that.

So, our message isn't nearly strong as the message that we put out saying, you know, we really like outcome measures better than some process measures, and definitely better than (shock full) measures, you know, not to that degree.

The trouble with composite measures is – this in general is that's a label that gets used for lots of different kind of constructed measures, and it actually makes it harder.

So, the idea of having a summary statistic that you do a lot of information about it just for a set of things is very appealing. But again, the devils in the detail, so, I don't think NQF has comedown quite as strong as you're thinking maybe it has.

In terms of – going to back to earlier question about the components of the composite, the developer is correct. We talked about that under sub-criteria in

1D from a conceptual level. And then, you're also going to talk about it again from an empirical stance under sub-criteria in 2D.

So, that comes a little bit after we finish talking about validity. So, you'll – we'll finish this discussion about any risk managements and the testing and that sort of thing and other things that come under validity. We'll vote on validity. And then, we'll go on to 2D which is talking about the empirical underpinnings of the components of the composite.

Ingrid Duva: OK. This is Ingrid. Thanks. And help me understand what is 2D.

Female: OK.

Anna McCollister-Slipp: This is Anna. And I'm not completely sure where to provide my comments. But I think that's just – at least the right spot for some of them. And again, to remind everyone on – here is the patient representative, I have Type 1 diabetes with multiple complications and I have two parents with Type 2 diabetes.

And part of me really likes this measure because it speaks very holistically about the whole patient as opposed to just focusing on individual components, and I think that's important.

And secondly, as someone who has complications, I basically, you know, had the benefit of doctors who would have gotten a high quality rating based on this measure, I've been on statin several times and basically I set all this criteria.

However, my mother has Type 2 and she is one of the rare people who have very severe reactions to statin. And fortunately, I didn't inherit that part but – that tendency. But twice, she's been prescribed statin because the doctor was a fairly decent doctor and he knew the benefit of statin. And he, too, probably, would score highly on the composite measure.

First time like Lipitor and she had very severe adverse events. But she had it for quite some time and he tested her for multiple (syringes) that have absolutely nothing to do with statins or diabetes.

I think he pushed – she was on – she had a lung issue. She was prescribed albuterol that are like steroids for her lungs. She had whole range of different side effects that went on for about a year. Before finally, she started breathing – adverse event of statins and realize that she was having an adverse event to Lipitor. We took her off Lipitor and it was completely resolved.

So fast forward, I don't know. Maybe, 10 years later, she had to adjust some other medication. And somebody in the doctor's office looked at her chart and said, Well, I don't know why you're not on statin.

They didn't see any notice about adverse events to prior statin. So they put her on a different (statin). She didn't recognize the name. But because the doctor's office was closely following, you know, clinical practice guidelines saying that statins are important for patient profile. The whole process repeated itself.

So, this time, it took her about six months to put the clues together. But there was no guidance whatsoever to go with the clinical guidelines to say, these are things you need to look for, if a patient is having these things, don't put them on albuterol. Take them of to statin

And I think that there's need to be some sort of a guidance based into recommendations about statin used, about the need to actively stream or just kind of a reaction because it had very significant severe consequences for my mother's life and her activity, her ability to exercise, her ability to be active in the church and peach …

Male: So …

(Crosstalk)

Anna McCollister-Slipp: … teacher …

Male: The important question is in a denominator exclusion, I don't see anything in there about allergic reactions as side effect statin or statin as counter indicated. Is there a mechanism in this item?

Robert Bailey: This is Bob Bailey. It says in the description of the measures, statin use unless contraindications or exceptions. I think in …

Male: OK.

Female: Yes.

(William Golden): And this is – this is Bill. In the flow diagram that they've given it list the several contraindications and exceptions the statin use. So, it's very nicely detailed on what would be excluded for keeping a patient out of the denominator.

Female: So I think Anna makes a good point. I think Anna makes – sorry. I think Anna makes a good point that it's – you know, I think clinicians and groups and everything do we need to be aware that it's not always going to be listed in an allergy list or, you know, some of these might have been years ago and – so I mean I just think it's something that – that, you know, we really need to make sure that people are aware of this possibility so that they can exclude people and – and that that can be documented in an ongoing way in medical records.

I mean, hopefully as we move into the future when medical records talk to each other better, you know, that sort of thing won't happen a second time.

Anna McCollister-Slipp: Yes. And again, I think Lipitor has worked very well for me. My complications have become stable. I worry a little bit about muscle recovery and mitochondrial issues but, you know, and the risk benefit since I choose to take it.

So, I've benefited, some of the people who adhere to this kind of quality measure. But there are consequences to really, just adherence to these kinds of quality measures. And my mother's life was very drastically affected and it could have impacted other factors and then – I mean very much impaired her functioning.

So, I think there needs to be a consequential guidance on how to figure out if your patient's having an adverse event with statin, just focusing on the outcomes measures themselves are even the process measures of prescribing these, is only one part of the picture.

So, how do you fix that in the measure like this? I'm not completely sure. You guys can figure that out. I mean I – you're, just wonder about the stuff we need. But I think if we're focused – especially for measure but looks at the whole patient like this which is great, there needs to be more than just check-the-box to see if there's a contraindications for statin. It's like do they have, you know, specific issues that would be – that would be suggestive that that patient is having an adverse event in statin.

Female: Yes, probably some, a point for the guidelines could also really be improved as opposed to, you know, the guidelines being too vague about it and then expecting the performance measure to be able to pull it out because you're sort of measuring after the fact when you do the performance measure.

Male: So …

Female: Right.

Male: … I think the point is well taken there.

Female: How soon we'll have a genetic test for it but we don't know yet.

Female: Yes.

Female: I'm sorry. Go ahead.

Male: So I think that – the point is well taken that this measure as well as others, you know, there are adverse effect of measures, I think we've seen that. It's in the (ammonia) measure and the timing of antibiotics et cetera. On the other hand, we do have rare events in some patients as oppose to the population. So they all kind of balances out and your point is well taken about being judicious rather than blindly adhering to the check-the-box.

On the meantime, though, we are ready to vote on the validity issues. I think your point has been well aired unless there are other questions …

William Taylor: One – one, I'm sorry.

Male: Go ahead

William Taylor: I do – thank you. This is Bill Taylor again. The place we ended – one of the places we ended last time was on the question of whether the all or non-nature of this composite is the right way to go, especially since it has the tobacco-free component in there. You could certainly imagine a patient getting top quality care who's on the statin, who's got blood pressure control where the clinician is working assiduously and diligently on helping the patient to get off tobacco. And yet that score would be just as bad as somebody were neglecting every one of those issues.

It's sort of ironic to – I think to consider the only passing score to be to get everything right when embedded in this is the statin recommendation which is based on a risks score, that takes into account multiple risk factors in several variables and, you know, it gives somebody a percentage risk of developing, you know, (ASCBD) in the next 10 years on a scale, right? And we're not scaling this at all. We're just saying, all or none, you need to get all of them correct in which gives you score well. Or if you miss even one of them, then your score is poorly as possible.

And the other concern that I have is the possibility of the disparities issues and seeing only adjustment in here that would pick up subgroups that might be more at risks for instance to smoke or to have cultural issues and make it more difficult to control blood pressure and so on. Economic issues that it's hard to be on a statin.

The only thing we haven't hear is the insurance product, lumping together for instance everybody who's on Medicare where you can't tell anything about sociodemographics except they are in America in over 65. So, I think it's a set up for two different problems. One is the (all) or non-measure of the composite and the other is the risk adjustment for sociodemographics using only insurance product.

William Curry: This is Bill Curry. So, this measure steward does talk a little bit about the first concern and they talk about the importance of groups to look at the performance of their providers on each of the individual components of the composite measure that that will help them to look at where efforts need to be perhaps apply to improve the care to those that they are serving. And I suspect that the practices that are at the top performers are doing things just like that to some degree.

So, I think they understand that – that this is going to be an issue that you could miss one of the component and then you miss the whole composite. But I think the intent is to have us to, as providers, to look at the patient as a whole and not just be aiming for glycemic control and or lipid control but to look at the whole patient and how we can holistically work with them to get them to the best data help.

The other thing is that, you know, when these measures are used by pairs or other quality groups that will perhaps be measuring performance at group level, I think the – they're never going to be set, I don't know, 100 percent. It's going to – they're going to have a threshold that they'll ask people to try to shoot for. But I think that they'll be realistic on where those thresholds will be set and the work that we've done with several of your payers here in Pennsylvania, they've been very reasonable about those thresholds for some of the composites that we're using.

(Jamie): Yes. This is (Jamie). I agree with – what you're saying. The validity – the comparisons or the validity is – the – if the risk adjustment is really a blunt object, but better than nothing I suppose.

The other issue we got, I mean if a person is basically deficient in only one of the components of the measure, it might be kind of a tendency to – for – let's say a plan to focus on those to be able to increase their numbers because if a person is deficient on three measures, the three parts of the composite they may feel like it you know, it's not worth it but at least for their score.

Now, I'm not saying that we have to at least think in that manner but certainly to be able to – like, you know, work on specific deficient measures might be theoretical plan.

William Taylor: Is there – this is Bill Taylor again. I think I'll be quiet after this one. I don't want to slow us down too much. But the – is it unrealistic to think that a medical group might be thinking of expanding into a minority community or insurance product might be thinking of, you know, advertising and trying to get more members into minority community and then they say, wait a minute. You know, there's a lot of tobacco advertised here, this will, you know, tobacco pushed heavily in this community which going to be really difficult to get these people to be tobacco free, so maybe we be better off not marketing there.

I think, isn't that a – is that a crazy (thought about) a non-intending consequence of a measure like this?

Female: I think that's an excellent point and that's, you know, one of my concerns as well. I mean, you know, I don't smoke, nobody in my family smoke. But I worry significantly about doctors being incentivized to avoid patients that are "difficult" or who have, you know, been quite difficult to control blood sugar or smoking or whatever the case might be.

I think we want to encourage good doctors to care of the patients that have difficult heath history as opposed to, you know, well, at the same time finding ways encourage those physicians to get their patients to change the behaviors, but all or nothing is concerning.

Sue Kirkman: So this is Sue Kirkman, I just wanted to go back to the risk adjustment piece and maybe I don't understand this completely but I think they're also are risks part in upon of over adjusting four things like socioeconomic status because – because you also don't want to get in to situation where you're sort of allowing "poor quality care" for, you know, poor and minority population.

So – I mean I'm sure this is a tension, you know, for NQF and for measure developers in general is that – is that, you know, lower socioeconomic status

patients, you know, often have worst control of risk factors and more unhealthy health behaviors and so forth and so on.

And so, you know, I just want to put in a plug for, you know, not sort of over adjusting for that and then ending up saying, you know, we sort of have different tiers of quality that we're going to fix up.

(Jessie): This is (Jessie). I apologize for joining late but I have been on for all of this particular discussion. And my feeling is that this is a good measure in the library of measures that we have for the reasons of all you were saying because from the point of view of evaluating what a physician is doing, this puts the physicians a little bit of a disadvantage because there are some things not in their control.

From the point of view of evaluating how well we're doing taking care of patients, this is a great measure because it looks at what we're actually achieving in terms of taking care of patients. And I agree with the last speaker that if it shows where we're not doing as well with some populations as others. And – so if was the only measure that we had in our library of measures, I think it would be more of a problem than having this as an endorsed measure in a context where we have other measures with the understanding that this measure gives you the point of view of how well we're succeeding at delivering good diabetes care to patients.

Ingrid Duva: Hi. This is Ingrid Duva. I just wanted to – I guess ask a question on that point. So when you say you have this composite measure but you also have other measures, are you're talking about continuing to look at the individual measures because I was asking my question from the construct standpoint of measuring an item that, that doesn't hang well with other items. And I've heard several people express concern about the tobacco-free because of the yes and no. And the other parts of the measure, the statin, the A1C, there's some sort of range whether or not it's exclusions or kind of the range because it's an A1V under 8.

So, I guess, that's why I was asking I do feel like it's important to understand if you're collecting an individual and the composite (inaudible) whether or not

the data, the item is actually sort of hang together and that is part of understanding the validity of it if it's representative of – you know, what it's actually representing.

Female: I mean you have this data if you – you've collected data across the state of Minnesota, do you have lots of data? So, I guess I've just been searching for whether or not that's addressed anywhere or is there possibility is not why it's not of interest?

Female: So you're saying people tend to do well, you know, sort of high, medium, or low on across all five components is your question?

Female: So my question is if we have like the data on the individual measures versus the data on the composite measure, I mean do we have one that actually falls out such as the tobacco free which does unfairly sort of represent the level of all these, so maybe it doesn't, maybe it is the threshold issue and up until a certain threshold, you know, you can have this patients who are just going to refuse to quit smoking no matter what you do, but it doesn't penalize you. It's not reflected poorly in your raw quality score because of the threshold issue.

Female: Maybe it is an issue and that's because it's a yes, no sort of binomial measure grouped in with this other measures that yes, I mean is DA 1C below eight or not, yes, no but it means eight is represented of an average, statins you get to have exclusions I mean the tobacco is yes, no they're tobacco free, there's no room there so, I'm saying conceptually it may not hang well as a composite it may be the composite measure doesn't represent well because that one that hang (inaudible) measures. (Inaudible) statistical standpoint when you're assessing, you know, validity and doesn't measure – measure what we think it measures.

So, I guest I just think that because there is concern out there I hear from the physicians and some people about this yes, no tobacco free sort of unfairly penalizing a high quality practice. You know, has that been looked at with the existing data or is it a plan or is there a reason why it hasn't because it's just basically a non issue perhaps it's because of the factoring in of the, you know, socio (factors), the types of insurance maybe it's just a threshold issue.

Female: But I don't – I guess my question is I see that we believe that this is, as a composite measure it recognizes quality of care because they're all important first of taking care of our diabetic patients but I don't see that it would analyze statically and I believe that it can be. But maybe I'm wrong.

Female: Is there a way to instead of just saying tobacco user yes, no, to say, you know, counseled on tobacco use or something, because you could be trying to quit but still a smoker.

Sue Kirkman: The problem is that such an easy box to check off I mean who wouldn't check that box so that's a lot current measures or like that, I mean.

I mean – so this is Sue Kirkman I mean I actually – I understand what people are saying about the tobacco none use but, you know, there is good data that what physicians do and tell patients and counsel patients does make a difference in terms of quitting rates I mean it's still the case and it's ultimately up to the patient and that they're going to be, you know, more patient who smoke in certain population but I don't really agree that it's not a measure in some ways of quality of care.

Male: I think we're going to – I think we've start to get into a big diminishing returns here a little bit. And I think this could go on for a while if we're not careful so. But I think the points that have been made by the speakers, are there additional points about the measure that (they) brought up?

Karen Johnson: Bill this is Karen from NQF I guess I just had one other question for the developers. I didn't see and this is really in the weeds and maybe it's there I need to see information about how good your model fit, your risk adjustment model, was that in the details of your submission and I just missed it or? You know, usually we look at scenes of (FX) and that first thing and I just didn't see that so I was just curious.

Jasmine Larson: So absolutely, this is Jasmine, you know, I have to be honest I'm not intimately familiar with every detail that was included in this submission but I will to say that when it comes to categorizing providers after risks adjustments, I mean we do look for a chi-squared and a T-test threshold for, to test the physical significance.

Female: OK.

Jasmine Larson: And I have the results of that for this measure. The chi-squared value is less than 0.0001 and the T-test is much less than 0.01.

Female: OK that's fine.

Male: Did you let at anytime, did you look at whether or not, those groups that made the measure you know, have had patients that made the measure whether or not that correlated well with those that made all but one of the measures or one of the components of the measure.

Female: All right, you know, I think my answer is going to maybe potentially answer the inverse of your question in that a chi-square analysis of the relationship between the adverse to affected frequency of each individual component compared to the optimal score does show a significant associations for each individual components.

Male: OK. That's useful for now.

Female: OK thank you.

Karen Johnson: And this is Karen that might be something that we will not talk about under 2D. So, we'll revisit that in a minute. I think Bill is probably right we're probably ready if nobody else has any questions or concerns I think we're probably ready to go to voting on validity.

Female: And a voting should be open by voting on validity for a measure 0729.

(Crosstalk)

Female: Yes.

Female: OK we have our 17 votes. One voted high, 11 voted moderate, four voted low and one voted inspection.

Male: So a moderate can as much as a high.

Male: It's all or none.

Male: That's what I was getting at.

Female: Yes, and it will past with at least 60 percent saying high or moderate will be a pass to this criterion.

And so our next sub-criterion is the empirical analysis of construction composite and I think we've talked about most of these issues already but the statement that the developer just made about the chi-square analysis showing that all the components contribute to the score if I understood that correctly. That might be something that you could elaborate on a little bit and then I think my other question was, I may have misunderstood what you submitted but I couldn't tell if you submitted an individual rates, the rates for the individual component or for everybody if you just hit for the top performing clinics.

But it kind of looks like they ask for a component was very high and if that's the case then I think the question there is, is it necessary for the composite if everybody is getting that one. And I'll stop in what the committee talked to.

Female: Did you want the developer to respond first or allow discussions?

Female: Why don't we let the committee see if they have other questions for you and then you can just kind of do one full swoop.

Female: Sounds but thank you.

Male: So the floor is open.

Male: Could you direct us to what test we're talking about now?

Female: Yes which is a two – are we on 2 B?

Female: No we're on 2D I'm sorry she had an ...

(Crosstalk)

Male: Can I get to advance the screen here?

Female: Yes.

Sue Kirkman: Yes that was my only notation this is Sue Kirkman, when I looked at it was just – that their performance rate for each component didn't seem to have been provided, it would have been useful to know or maybe I didn't miss that.

Female: Boy I can't run this now, Kaitlynn was doing a better job than I am, hang on just a second. Yes I know at the beginning of our discussion is this last – there we go. Beginning of our last call the developers gave some overall percentages for the components and it looked like they – maybe I just misunderstood what was submitted earlier as well.

So, I guest my question is, you know, basically the main question is, is the aspirin component topped out? And that's probably the best way to put in and then maybe compare that with your statement about chi-square showing that all the components contribute to the composite.

Ingrid Duva: And Karen this is Ingrid Duva again, I'm sorry, I'm just going to apologize for bringing up my conversation under 2D because it really references 2D and I think the chi-square test might be support –support the answers that I'm asking for too so but I can't …

Karen Johnson: Yes.

Ingrid Duva: … find the chi-square test.

(Colette): Hi this is (Colette) I'm going to start with the composite rates, they were provided, the component. Individual rates they were provided in 1B2 under the performance scores. And the A1C was 73.7, LDLF on a hundred with 63.7, blood pressure less than 140 over 90, 84.3 daily aspirin or antiplatelet use, if ischemic vascular disease, no counter indications was 99.5, and tobacco none user was at 84.5 percent.

And I'd like to talk a little bit about the aspirin anti-platelet use itself. Yes, in Minnesota, one could look at this and say that component is topped out but

here we've been working on this for several years. In 2010 we were at 85.9 percent, so have increased 13.6 points over the last four years.

We understand that the rest of the country is not yet topped out in terms of appropriate use for secondary prevention. A 2013 New England Journal of Medicine article demonstrates that only 46.9 percent of the patients were prescribed aspirin anti platelets in the hospital setting and 34.8 in the primary care setting.

Also this measure has been used the last three years on the Accountable Care Program and there is some – still some variation in the aspirin component with an average of 83.9 percent and a range of 54 to 100 percent in the pioneer ACO model and in the Medicare shared savings program, that average was 75.3 percent.

So nationally still some opportunities for this component, less opportunity here in Minnesota.

Female: Great that's very helpful.

Female: Yes.

Sue Kirkman: This is Sue Kirkman so it sounds like, you know, it's, even in Minnesota there has been a merge increase, you know, probably with use of this measure. So maybe when it come up for renewal in another three years or something if it's still at 99 percent, you know, it maybe it should be dropped then but it seems to me like if you sort of just gotten topped out and it wouldn't be right to drop it now or change it now.

Male: Or even if that, if one component is highly – has a high rate of success, it essentially becomes, it (creates) space on a composite measure. So, it's just background noise it really isn't that critical. The only problem would be it would be the burden of cost in the data.

Male: But what we heard from the measure steward it sounds like that it's used in other programs other then the Minnesota program, so, it's something that probably should still reside within the composite measure.

Male: Are you ready talk about other parts? Are we still going to talk about the aspirin?

(Crosstalk)

Female: Yes, any other part.

Bill Taylor: This is Bill Taylor again. Before I suggest that aggregation of waiting rules are not needed because it's all or none measure but that's actually an aggregation in waiting rule but nothing counts unless everything is achieved is the waiting rule.

You get a zero on A1C and a zero on statin and a zero on blood pressure and then on zero on tobacco unless you get all of them. That's the waiting rule.

And I think it is – I said before, it's a – I think it's a mistake well it doesn't capture quality so I think the waiting rule does need to be thought about. And my opinion is deficient.

Karen Johnson: So this is Karen. I think you have the tobacco question is something I think you still need to talk about a little bit more. But in terms of that statement in the preliminary analysis, what I was trying to convey there is that they don't really need to do additional empirical analysis.

I look on composite measures that are built differently than all our non-measures, there is analytic techniques to look at that – the grade of which things hang together for lack of a better way to describe it.

But with these all or non-measures, there's really not a lot of empirical stuff that they can do, more one of them, they just done which is tell us what the individual components are and what the rates are for that.

And I actually will probably try to talk to (Colette) a little bit later to make sure I understand the chi-square stuff that she did because that would be a new tool in my tool box to understand.

But that's what that statement meant. You're exactly right. The all or none that is an aggregation method and it's also a waiting method. They're equally waited.

So, that's what that statement meant. But going back to the question about tobacco free, I'm not sure if the committee wants me to discuss that more.

Male: It might be helpful to understand what the impact of that measure has done on performance very much like we heard with aspirin as well.

(Colette): Hi, this is (Colette) again. I don't have exact facts in front of me but I do know that tobacco use rate in Minnesota have decreased over, I want to say the last six or seven years in the general population.

Actually, oh Jasmine's pointing to my own data rate in front of my face. We've had a couple percentage points increase and keep in mind, this is on a very large denominator of over 230,000 patients.

We have seen about 2.5 percent increase in tobacco free patients.

Male: Additional comments for construction? Are you ready to vote?

Female: OK, we'll pull up the voting sites, voting should be opened. We're voting on the construction to measure 0729.

OK, thank you. It looks like we have 16 votes. I think that's enough to move along, the measure passes.

Female: One voted high, 10 voted moderate, four voted low and one voted insufficient.

Female: OK. And with that, let's move on to the next criteria, feasibility.

Bill Curry: So this Bill Curry. The data, I think for the most part is easily obtained from the EHR.

Some of the exclusions especially for the statin use may need to have some manual review of the E.A. chart to find them. If they're not somehow coded in a common data element that that can be pulled out or searched upon.

But I think that's not a big issue. So I think that it's a very feasible composite major to be able to collect at a practice or a group of them.

Male: So just to be clear because this came up at a previous measure. Were voting on an (E) measure here which could be collected or paper measure because that has a big impact on voting for feasibility.

If we're voting about easily extracted from an (EMR), we would need the – those criteria. But I don't believe those have been submitted.

Janet, can you clarify this from NQF stat?

Janet Sullivan: Yes, this measure has not been submitted as a formal E measure. My understanding of this measure is however, it's a little tricky but this measure could be – data from it could be collected from data that are stored in EHRs.

But it's not an official E measure and I'll stop there and make sure that the developer (leaves) with that statement.

Female: That is absolutely correct. It's not specified as an E measure with the measure offering tool.

Male: Well I can tell you from in my jurisdiction the ease of extracting this kind of data is not easy. So, it's a very mix picture of this.

Female: And Bill, do you mean that in terms of as extracting from EHRs or from paper or from either?

Male: Well paper would be very burdensome and EHRs would be tricky, a lot of practices. The capacity is only emerging now. And that's been a problem with the CTCI, a lot of the medical home practices.

The capacity for EMR is to extract data consistently. It's been very next to picture not nationwide and particularly in areas like mine.

Sue Kirkland: So this is Sue Kirkland. But is that any different for this measure than all other measures, I mean they, it sounds like they have pretty much every practice in Minnesota reporting this now so …

Male: They have a very high prevalence of larger organizations in EMR base so it's a very different environment than in here.

Sue Kirkland: But I guess again, are your comments, really just in generally about quality measures as opposed to …

Male: Well, this is a – this would be a clinical data intensive composite measure. So it requires collecting multiple elements out of a medical chart as opposed to one element, two elements or administrative date.

William Curry: So maybe, the measure steward – this is Bill Curry, may be the measure steward could just talk about those practices that did not have an EHR and the ability to submit a random sampling of their practice.

Can you talk about that?

Jasmine Larson: Certainly. This is Jasmine. I'll start with some comments and (Colette) may offer a couple additional points.

Every clinic and does submit data and we do have somewhat unique environment and that we have a state mandate around quality reporting that this measure is included in.

And the comments are with correct and that our market is also a little bit different and that we have numerous large group practices with E sources may be not available to smaller practices.

That being said, we still do have smaller practices. And some even still on paper charts that do successfully submit data on this measure.

Clinics that EHR implemented for one year or longer are required to submit total eligible population data. And do so and have done so successfully for many years.

And then practices that have been on an EHR less than one year do have the option to submit a random sample.

And (Colette) may have more specifics about the incidents of how many clinics actually submit a sample for subtotal population.

(Colette): I wonder if I'm – I want to say, when I look at our overall stat, we are getting 97.2 percent of all eligible patients.

So, when we're talking about eligible patient, that is the number in the practice that meets the denominator criteria. So if I do the reverse of that, I have about 2.8 percent of all patients are in a clinic where sampling is occurring because they were on a paper record or because they haven't been on EMR more than a year.

And I just like to comment. You know, granted this measure has been in place for several years in Minnesota, several of the elements are, you know, once you figure out how to pull your most recent A1C in a timeframe, that's pretty standard and doable for the practices same for blood pressure.

We do recognize within a statin component, where the contraindications and exceptions and we have several that we will accept. Kind of commenting earlier about adverse events in patients.

We have allowances for allergy, for drug interaction, for prior intolerance, addition to all the clinical conditions where statins would be contraindicated.

This new component of our measure would be a little bit burdensome in terms of collecting those exceptions to statin use, however, we felt or the development workgroup felt that in the interest of patient's safety, we had to have those allowances.

But keeping in mind in the beginning of the very algorithm if a patient is on a statin, there's no further data collection to be collected so that eases the burden somewhat as well.

Female: Any other comments on feasibility?

(Jessie): This is (Jessie), I just wanted to know, may be I missed this, if the – when you said patient on a statin, I believe the measure is coded so that it's – if a statin has been prescribed, is there any way of also adding if a statin description has been filled? I'm just curious about the data sources.

Female: Thank you for catching me on my words. This information is coming from the practices. So, when we specify that individual data field, we are saying prescribed, ordered, on your active medication list or documented in your progress notes, we'll accept any of those.

It is not a claims base measure and we do not have access to prescriptions filled.

(Jessie): OK, thank you.

Female: OK, we are prepared to open voting unless there are any other comments.

And voting is opened. We're voting on feasibility to measure 0729.

And then we have 13 votes.

Anna McCollister-Slipp: This is Anna. My screen hasn't changed by the voting so I don't know …

Female: Anna, if the boxes are not showing up to the side, you can refresh your session. You could do that by refreshing your browser line pressing F5 on your keyboard also.

Female: Has anybody not been able to vote?

Male: Some people dropped out.

Female: Yes I'm afraid we may have lost somebody at 4:30. Looks like we're at 14 if I'm doing my math correctly, technically, we need 15 I think in this case, would be OK to go forward.

We may have to – we'll consult others here to see if we need to try to …

Male: Well, if you count a – if you count 15 vote is a negative, you would still be sufficient.

Female: Yes, yes, we don't – I don't think we would have enough to flip this, yes.

Male: Well, if you just take to default, missing voters are negative.

Female: All right. We can do that. Thank you, (Bill).

All right. So, Kaitlynn, you want to read out our numbers?

Kaitlynn Robinson: Sure. For feasibility, seven voted high, four voted moderated, three voted low and zero voted insufficient so this passes.

Female: OK. Usability and use.

Male: Well, are we going to continue if we don't have a quorum so I'll have to do electronic voting?

Female: I think we can go ahead and continue the – let's go ahead and continue to see if we can stay around the 14 marks.

Because usability and use of feasibility, neither of those are must pass criteria.

Male: OK.

William Curry: So I think – this is Bill Curry. I think we've heard from the measure steward that it has been in use and they are doing well to collect the data for the composite major throughout the state of Minnesota so I think usability has been good.

What strikes me in this is that when we listen to the numbers per each of the components, how high the percentages of the individual components are in terms of successful completion?

And if, you know, a practice or a group were to list those individually, they could, you know, look like they're doing really well and they aren't doing really well.

But when you put them together as a composite, the best that the state has been able to do on average is about 40 percent or little less than 40 percent. So, despite those high numbers, the composite performance is – it's sobering.

And to me, I think that just helps me to better understand my lack of sometimes looking at the patient as whole. And that's where I think the benefit of a composite major like this is of significant value.

So, I think that there's – they're easily used and there's good usability and I think that – I don't see that there's a lot in terms of unintended consequences but I think there are some really positive consequences that can come from looking at a composite like this.

Sue Kirkman: So this is Sue Kirkman. So, also under usability, I mean, they do describe five, you know, current uses of this measure, you know, it's publicly reported, they're using it for payment. They're using it for accreditation in (ACOs) and so forth.

So, you know, it's – I mean, I think they show evidence that it is being used in multiple ways which is what I think usability is suppose to be measuring, so I mean, I don't – I'm just a little worried about the time just because I do – I have a (hard stop) at 5 and I want to make sure that we do continue to have enough people to vote.

So I'm hoping that we can kind of vote on this one fairly quickly.

Male: Yes. Let's start on this.

Sue Kirkland: I don't mean to cut off discussion but …

Female: OK, we are pulling up the slides.

Bill Taylor: It's just that I didn't say it before but – it's Bill Taylor again, what we said about unintended consequences in validity maybe is applicable to this vote.

Female: That's correct. And voting is opened for usability and use measure 0729.

And we have 15 votes for usability and use. Five voted high, seven voted moderate, four voted low and zero voted insufficient, 16 votes.

Male: We have a quorum.

Female: We do. All right.

So with that, we can go on to the overall suitability for endorsement.

If the committee has further comments or if we feel we're ready to go ahead and vote, we can do that as well.

With no comments, we will open voting. Overall suitability for measure 0729.

Then we have 16 votes. So, overall suitability for endorsement, 12 voted yes and 4 voted no.

Female: Great. So that took us a little longer that we expected but that's OK. We got a lot of good stuff so we can write a critical report.

The next portion of the call, we have maybe 5 or 10 minutes to discuss pretty briefly but we really just wanted to get your thoughts on this and I don't know that we are even want to go so far as to think about official vote, just kind of depends on what you're thinking. But, you know, that usually about this time we start thinking about related and competing measures.

So, obviously, the measures that are competing is this composite measure, are measures that look at the individual component. So – or last week we looked at the blood pressure management or blood pressure control measure, so that way it could be considered competing with the composite measure. Back in cycle 1, we looked at an HB A1C control measure less than 8 percent, that one could be considered competing as well.

So, I think we've heard from the Committee and I think it was Bill who said this but I might have it wrong. We understand now what the composite is doing over and above the individual measures that, you know, maybe practices we are looking really good on one or two, the individual measure

still may not be able to do well across the board. And I think that probably speaks to the utility and the usefulness of the composite.

So, now I just want your thoughts about continuing to look at the individual measures themselves. Is it still useful to have the individual measures that we have? And …

(Crosstalk)

Female: Go ahead. Go ahead.

James Dudl: This is Jim Dudl. Interestingly enough, I listened to Bill Taylor's comments and integrating them, and everybody else's comments. I'm a strong proponent that these are not competing but they give us different tools.

Inside of Kaiser, you know, we have looked at a composite measure for cardiovascular forever, and we looked at individuals. The composites, you know, started out at 30 percent, 40 percent and of course everybody looked at and pretty terrible then we – but we – we actually went after by looking at the individual measures.

We started about 15 years ago with smoking after we worked out process and whatever made improvements way back 10 years ago went after lipids which was a totally different way of approach and five years ago we went after hypertension which is a different approach.

So, we looked at them both and we continue to move and then on individual of course we looked at one of the – one, two or three things that are missing and go after that. So, in our view, we never looked at them individually. We looked at both the composite and the individuals. I don't think you're competing.

Patricia McDermott: Why I would agree with that? This is Patty McDermott. We – you got huge value of much better discussion if there's anything else with providers when you look at individual measures and then individual metric through literature performance. A composite measure might tell you something but it really doesn't tell them where their pitfalls are.

So, I'm a huge proponent as well of individual measures. And then if you want to use it in the composite fashion worrying about all the biases that we've discussed today that's fine, but at least you have individual measures. And again, one important points of the individual measures, some of these measures can be gathered administratively and some of them can't very well.

So it's really important for those of us that are looking for efficiency and measure gathering to be able to use those administrative measure as we want to and not have to be limited because – in order for it to be considered valuable, it also has the abstract in measurement. Thank you.

(Bill Crager): I would agree with – this is (Bill Crager), with the comments that have been made. One challenge that I think that will come up is with the statins. And so, I don't know that there is currently an individual measure for the statins that I've seen. And maybe it's been developed and we haven't looked at it or in another working group. But, the question came up earlier about, do we collect this out of the EMR? Or do we collect it from claims data? And that can create some real challenges, especially in the letter when we have patients that will get prescriptions filled at retail pharmacies that do not send the data or send the claims to the carriers or the payers because of the low cost of their prescription.

So, we have a large paper value program with one of our payers and yet some of our patients of--pretty sizable number of our patients are getting their prescriptions from Wal-Mart and another pharmacy that has low cost statins and ACE and ARBs. And so, we're not getting credit even though it's well-documented in the record that the patients are taking these medications. But, the payer never sees it. So it depends on who's collecting that data and how it's collected as to how well a practice is as measured as performing.

Male: I do believe that there is a measure I think in the portfolio somewhere of statins for diabetics over the age of 40 and we talked about that in the last call.

Starlin Haydon-Greatting: Yes this is Starlin and our last – when we were there last year, we talked about statin use in patients with diabetes. I also know that the Pharmacy Quality Alliance is developing an adherence measure specifically

for patients with diabetes on looking at the percentage of use with that claims data. So that it can partner with some of the EMR that we're exploring, trying to make this more logical, so.

Male: So, just to clarify from – to the staff the issue on the table is whether we endorse both or choose one over the other because of redundancy. That's to make sure we have – We're focusing our discussion on the conflict here.

Female: Yes, yes that would be basically the question. Again I didn't really think that it would maybe go to a formal vote but I wanted to hear your suggestion if it is – if I was hearing something different, I would be thinking that we might do need to go to a vote.

Male: So I just want to – let me turn the question around then to the group. Is there anyone in here that is uncomfortable endorsing both, i.e., they prefer to endorse only one of the two?

Bill Taylor: This is Bill Taylor. Could we hear a little sort of from a higher level of what are the pro's and con's of you know, how serious is the problem of redundancy? How important it is that we you know tear things down at the minimum and say there's no difficulty to just add more things of who we get a moment on that to put it in context?

Female: I can take a shot in the staff that it might be better from other committee members.

Sue Kirkman: So this is Sue Kirkman I mean I – somebody said earlier something about these are complementary not redundant. I mean it's – I think it's a very different thing to look at individual measures versus that composite measure which might have some overlap with you know, some of the components of the composite measure have overlap with other performance measures.

So I see them as complementary and not really redundant.

Robert Bailey: And this is Bob Bailey. I'd also like to weigh in specifically on this insurance to statins, I think you know, in the absence of there being intermediate outcomes such as target LDL cholesterol now, it's important to measure both

whether it was prescribed and whether it's being adhered to, you know, at some level inline – with how it's prescribed as well.

Bill Taylor: Bill Taylor again. I don't have a sense of whether there's any mandate to us or to understand the pro's and con's of having additional measures versus being conscientious about tearing things down and you know, making sure that we do our best to eliminate redundancy. There's no cost to having another measure. Of course, it gives you another perspective and we should add it. But if this, you know, if there's a downside to what we should understand what that is and take it into account.

Male: I think there is a history of wanting to have harmonization so you don't have two or three measures, measuring the same thing. So in this case, they're measuring related things but they're doing it in different ways. So it's not quite that there is a redundancy, I mean I'm strict with redundancy but there is a related redundancy. I think it's the notion of harmonization.

Female: I would agree. I think this is complementary because of the individual measures that we have and not an additional burden for no good reason.

Male: Further discussion?

Are we getting to the wrap up here? We have other items for our agenda?

Katie Streeter: We do. At this time, I just like to open up for a public comment quickly and then Kaitlynn will go over our next steps for this project.

(Bridgette), if we could open up the line for comments?

Operator: At this time, if you would like to make a public comment, press star one. Again, to make a public comment, please press star one.

And there are no public comments at this time.

Katie Streeter: Great thank you. So I'll turn it over to Kaitlynn she's going to briefly go over the next steps.

Kaitlynn Robinson-Ector: OK, so the next major event is about (team) member's comments and that's going to be taking place between March 5th and April 3rd and the drafts report will be completed and posted for public comment on March 5th. And the next thing would be for the comment calls of those standing committee, not only taking place on April 16th from 12 p.m. to 2 p.m. Eastern time.

Then there is member voting period and that will be taking place between April 23rd and May 7th. Next would be measures will be going to the consensus standards advisory committee review and that will be taking place on May 12. Next to measures will go to board ratification and that will take place in June. And the appeals period will be taking place between July 1st and July 30th.

Katie Streeter: Great thank you. Thank you everyone for taking the time today. We're so glad that we had enough members voting online and this will conclude the endocrine project. As of right now, we just have three measures for this phase of the project. This is the third and last cycle and we will be in touch with you as we progress through the process for cycle three. And again, we thank you so much.

Any closing remarks from our co-chairs?

Male: Not for me.

Male: Not for me.

Male: I thank you.

Katie Streeter: OK thank you all. Thank you to our developers as well.

Female: Thank you. Bye-bye.

Male: Bye.

Female: Bye.

Female: Bye-bye.

END