NATIONAL QUALITY FORUM

Moderator: Endocrine Standing Committee
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OPERATOR: This is Conference # 38893202

Katie Streeter: Hi, good afternoon everybody this is Katie Streeter, Senior Project Manager here at NQF. And I'm in the room with Karen Johnson, Senior Director, and Kaitlynn Robinson-Ector, Project Analyst.

Welcome to the Endocrine Cycle 3 Standing Committee Post-Comment Call. This is actually, probably, the last webinar call that we will have as part of this project. Thank you for taking the time to be with us today.

We will be reviewing the comments that we received in Cycle 3 and also responses received from developers as well as proposed responses from the committee. Before us proceeding, I'd like to stop and take a quick roll call.

Do we have Dr. Golden on the line? Dr. Rosenzweig?

James Rosenzweig: I'm here.

Katie Streeter: Bob Bailey.

Robert Bailey: Good afternoon, I'm here.

Katie Streeter: Dr. Breen? Dr. Curry?

Female: Yes, I'm here.

Was it Tracey – I'm sorry. Who was that? I'm sorry. Vicky Ducworth?

Vicky Ducworth: Yes, I'm here.

William Golden: Hello.

Katie Streeter: Hello, who's this?

William Golden: This is Dr. Golden. Will Golden.

Katie Streeter: Hi, there. Thanks for joining we're just going through roll call. Dr. Dudl?

James Dudl: Here.

Katie Streeter: Ingrid Duva? Starlin Haydon-Greatting?.

Starlin Haydon-Greatting: Here.

Katie Streeter: Dr. Kearns?

Ann Kearns: Yes.

Katie Streeter: Dr. Kirkman?

Sue Kirkman: I'm here.

Katie Streeter: Dr. Leddy?

Anne Leddy: I'm here, too.

Katie Streeter: Dr. Lee? Dr. Makaroff?

Laura Makaroff: I'm here, Laura Makaroff. Thank you.

Katie Streeter: Thanks. Anna McCollister-Slipp?

Anna McCollister-Slipp: I'm here.

Katie Streeter: Patty McDermott? Janice Miller?

Janice Miller: Present.

Katie Streeter: Claudia Shwide-Slavin? Jessie Sullivan? And Bill Taylor?

William Taylor: I'm here. I apologize I have to leave at 1 o'clock.

Katie Streeter: OK, thanks. Just going back. Do we have Tracy Breen on the line? Bill Curry? OK. Do we have any of our developers on the line with us, NCQA or in Minnesota?

Collette Pitzen: This is Collette Pitzen at Minnesota Community Measurement.

Katie Streeter: Hi, Collette. OK. I think we can go ahead and get started. Like I said, today, we'll be reviewing the comments received and our proposed responses. Staff did prepare a memo for you that highlights and outlines the comments received. And now, I'll turn it over to Karen, Senior Director, to walk us through that memo and facilitate the discussion.

Karen Johnson. Thank you, Katie, and good afternoon, everybody. We did receive six comments on the two measures. And the first comment that – we just want to make sure you knew about was one comment that came through on the blood pressure control measure and that was a supportive comment. So, we don't really need to do anything with that other than for us to let you know that came in.

The remainders of the comments were in response to the Optimal Diabetes Care Measure, 0729, and hopefully the memo is not confusing to you. But sometimes when folks send in comments, often they send in or they submit one comment but they have several things to say in the same comment. So, we broke those out and grouped them to the extent that we could.

So, the five comments actually had several different things that came through about the Optimal Diabetes Care measure. And I think we probably just want to discuss them in the order that they come in the memo. And I'm going to tee up but just the first piece of the discussion and then I'm going to hand it over to Bill and Jamie to facilitate the committee discussion.

So, the one comment has to do with – or the first comment that I wanted to talk about has to do with – actually, two comments that came in, one from CMS actually. And it's referring to a fairly nearly published report, the National Action Plan for Adverse Event Prevention. And we gave you the link to that report. But in that report they are less than thrilled with the idea of an HbA1c measure less than 8 percent unless there are some specific exclusions to the measure.

So, the comments – we provided also the Excel file for you and hopefully you were able to actually look at the full detail of the comment because the memo just kind of summarizes things so hopefully you saw everything. But really the gist for the comment or what I want to make sure that everybody is clear about is that the comment didn't offer any new evidence that you guys as a committee had not already considered. But basically it's saying, "Look, a bunch of federal and non-federal folks got together. They came up with the National Action Plan for Adverse Event Prevention, and they had concerns about the HbA1c measure."

So, that's the context that we want you to discuss this measure under and really just to kind of tee up your option that you have after we discuss this comment as well as the other things that people talked about. You really probably have three options. One is if these comments concern you enough, you may decide that you would like to reconsider your vote. So you did vote in our last web meeting to recommend this measure for endorsement. So, one option would be to reconsider that decision. And if so, we would actually have you either on the call or after the call depending on what happens. We would actually have you vote. Your other option would be to have a discussion but decide that that doesn't really change your mind and you don't want to revote. And then kind of the third is a little bit of in the middle that maybe the discussion isn't enough necessarily to change your mind about how you want to vote or what you would recommend for the measure. But you may want to make recommendations regarding the measure to the developer for the next time that they come to NQF.

And just to make sure everybody understands, you know, these kinds of recommendations that you would make in the committee to the developer, if

you decide to do so, would be in the spirit of advice and recommendation, but not something that would be binding on the developer. They would still have the option, of course, to take or leave your recommendations. And then, of course, when it comes back for review later, if that's how it went then that would be taken into account by the committee that looks at it, you know, the next time we meet. So, hopefully that is clear.

And with that, I think I'm going to turn it over to Bill, I guess, if you want …

Sue Kirkman: Sorry, can I ask a question?

Karen Johnson: Oh, certainly.

Sue Kirkman: This is Sue Kirkman. I'm sorry if I missed an e-mail or something, but where is this memo? Because what's on the screen is not – it's only like part of a page.

Karen Jonhson: Right. OK …

Katie Streeter: I can e-mail it real quickly to you if that would be helpful.

Sue Kirkman: Yes. I don't know if I'm the only one that missed it or if I was supposed to go on the shared drive to see it.

Katie Streeter: It is posted on SharePoint. Did anyone else miss the memo?

Robert Bailey: Hey, could you send it to Bob Bailey as well please?

Male: Why don't you send it to us all?

Katie Streeter: Yes, I'll do that now.

Sue Kirkman: OK, thanks.

Karen Johnson: OK. And, Kaitlynn, did you – I didn't ask you and I'm sorry I didn't think to ask you. Did you happen to load that National Action Plan? Do you have that available?

Kaitlynn Robinson-Ector: I do not, but I can open it.

Karen Johnson: OK. We might ask you to open that if we need to look at it. It's really only two pages of the plan. But if you want to see exactly what it says, it's really the CMS comment, I think, that hopefully you have had a chance to look at. It does lay out their concerns, so you don't really have to see the plans. But we'll open it.

If you go to page 117, if you would – and then once you got that up, you can put that to our memo.

William Golden: So let me – let me open up the conversation. I, for a long time was concerned about, you know, hemoglobin A1c target of 7, which could be problematic in some population. I haven't seen much about 8 being a concern. I reviewed with staff, you know, their thoughts about their memo and, you know, other than from slipping the measure to percentage of patients with poor control, which would be, you know, greater than 9. You know, the 8 seemed reasonable. And if they were a few exceptions, there would be a small fragments of the population as opposed to a significant portion of the patients in a usual practice.

So, I thought that the staff memos seemed reasonable, but I'll certainly open it up for conversation. But I'm particularly interested if anybody had heard that hemoglobin A1c target of 8 was problematic. That's sort of a new one on the terms of concerns.

Sue Kirkman: Yes. And I don't agree with their comment that it's not consistent with American Diabetes Association guidelines. You know, I know there are some VA guidelines that have an even higher target than that for certain populations but I just – I don't agree with that comment.

William Golden: Everyone will have a high risk patient or two where you …

(Crosstalk)

Sue Kirkman: Yes.

William Kirkman: It's not really a concern, but if you start to really tinker with that, you end up with not much left.

James Rosenzweig: Yes and this is Jamie. I agree with both of you except for the fact that I guess the guidelines of the VA do sort of suggest that patients will have like a limited life expectancy or less than five years to live. This is what I think they turned into – they should be excluded from this kind of a target. And the American Geriatric Society have, you know, specifically are dealing with a patient population that is largely elderly. And, so they were concerned about it, as well as comorbid conditions.

Now, I think this guideline or this particular measure deals with patients age 75 or younger. Isn't that right?

Katie Streeter: Yes.

Karen Johnson: Yes. That is correct.

James Rosenzweig: Yes. So, at least with respect to the very elderly, it's not indicated. But I think, probably, we have really have choices. We discussed this at length at our last conference before we voted on it. The issue is whether or not we want to add extra situations where we would – extra exclusions related to some of the things that they're mentioning or whether we should just confirm what we originally voted for, I think that would be the major thing we have to think about.

Anne Leddy: Well, this is Anne Leddy speaking. I missed the call in January. So I wasn't part of that discussion. But I think what CMS is focusing on here is the overwhelming expense and morbidity related to hypoglycemia and they have put together a very aggressive plan to ameliorate that. And I personally read all of this as saying that really the only way to work this out is to have two populations -- the relatively healthy diabetic who most of us see in our practices; and then the very high-risk diabetic patients of long-standing who are elderly or frail, have a lot of impediments.

I think (we were) surprised to – I mean I read Dr. (Coler's) comment very carefully and she listed a very high percentage of medical beneficiaries over

65 who had risk factors for hypoglycemia. And so, I would like to see the present measure continued but would probably suggest since in this very extensive report about hypoglycemia that new quality measures be developed to prevent hypoglycemia at multiple levels. But that'd be worked on separately.

William Golden: You know, obviously, you can find risk factors just for anything. Do we have data on the number of actual events in terms – you said there's a high expense (thing). You know, in my experience over time, I haven't seen that much of it so I was just curious how prevalent is that out there?

Anne Leddy: Well …

William Golden: Or is it the quality of care issue that we reflected in practices more than, you know.

Anne Leddy: Yes. I did not read the whole report but they do indicate that there are over 280,000 admissions a year for adverse drug events related to insulin therapy or insulin secreted GAGs. And so that, you know, equates to very high national burden for this type of hospital admission. And so, it's a significant thing for the country, but you know, in any particular practice, you know, we all have, you know, a small number of patients who are at risk for this.

Sue Kirkman: The only thing is that hypoglycemia is not necessarily related to the achieved hemoglobin 1Ac and the type 2 population …

Anne Leddy: Absolutely.

Sue Kirkman: Studies like the ACCORD trial and the VA diabetes trial, the highest rates of hypoglycemia were in people with higher A1cs. So, you know, to sort of say that in A1c of, you know, 7.6 percent and someone on metformin, you know, is risky, is, you know, is just – it just doesn't go along with the evidence. I mean it's really – it's probably more related to the type of therapy that people are on and to, you know, patient factors rather than what the achieved A1c is.

William Taylor: This is Bill Taylor. Isn't there a problem when we have a measure like a goal of A1c of 8 or lower that we know that many of the people who will be aware

of the measure are not studying the details of what we're recommending will be getting a sense that they're being judged and paid based on A1cs, and will misapply what we recommend and will be treating people over 75 or people with short life expectancies or multiple comorbidities.

Can we expect that that's part of the – I guess we talked about – when we talked about it before, we spoke about unattended consequence. But in the world of primary care as opposed to the world of endocrinology, isn't there something we have to think about when we, you know, in light of the admonition about watching out for adverse events even if, you know, people who experience hypoglycemia maybe they have higher A1cs and so on? Isn't that part of this unattended consequence part of our making a standard here that we have to factor into how we consider this?

William Golden: Do we have anyone on the call that would – you know, we see the proposed response from NQF staff. Does anybody have objections or concerns about the proposed wording from the staff?

Sue Kirkman: What that would be? Can somebody from NQF walk through (inaudible) or recommending briefly?

William Golden: It should be in the documents you got in the e-mail. Where was it now, on page …

Female: It is on the screen now…

Male: It's on screen right now.

Female: Yes.

William Golden: Page 3, page 3, yes.

Female: On the screen.

Karen Johnson: Yes, it's a bit of a long-winded comment because I wrote it, and I tend to be a little bit long-winded. But basically, I wanted to make sure the same response that you guys were familiar and had discussed in your previous discussions

the various guidelines that were mentioned in the comment. So that's the most of it.

And then the final (tenet) is kind of a gist. And again, this is (for proposed), you guys could (inaudible) way from this. That's why they acknowledge that the less than 8 percent threshold may not be appropriate for all patients. They agreed that the 8 percent cutoff was a reasonable target for national healthcare performance measure and that 100 percent performance on the measure is not expected.

William Golden: I agree with that.

Karen Johnson: Looks like …

Sue Kirkman: Yes, I mean we could make the same argument about the blood pressure, you know, part of this composite measure. You know, it's not appropriate for a 100 percent of people but yes.

Karen Johnson: Yes.

Collette Pitzen: Karen, this is Collette at Minnesota Community Measurement, may I make a clarification?

Karen Johnson: Certainly.

Collette Pitzen: Maybe perhaps the comment could include exclusion components that are existing for the measure, emphasizing that we do have an upper age cutoff of 75 years. We also allow exclusions for permanent nursing home residents or for patients who are receiving hospice or palliative care services to perhaps hit some of those patients that are in the 60 to 75 year range that have more going on. But we do have some exclusions to the measure as well. Thanks.

Karen Johnson: Committee?

(Crosstalk)

Starlin Haydon-Greatting: Yes, I agree with that. This is Starlin.

Male: Yes.

Karen Johnson: OK.

William Taylor: I agree with that.

Karen Johnson: OK.

Starlin Haydon-Greatting: I think – this is Starlin. I think – I attended the adverse drugs event. We had a seminar. They came to the Pharmacy Associations. And I think they're really very concerned about the population that goes low and shows up in the emergency room or the population that goes so low that they fall. And so, it's somewhat tied in to their concern on a group of patients over this age of 55 falling because of a hypoglycemic event. And our feedback to them really talk more about the combination of oral for type 2 patients, the combination of oral medicines that contribute towards that hypoglycemia more prevalently than some of the newer combination.

And so, we can't really write the measure about that because of the push to put everybody on the generic medications. But that was our comment back to them about that concern and you guys touched on this. But I just wanted to say, it's, you know, the (inaudible) are the generic drugs that everybody's being put on. And if you are in this older group and you're on a combination and they do start from sort of injectable, it will completely bottom you out and then you end up into the ER. So we were trying to caution them about the drug combinations that are out there that the Medicare Part E population has being pushed toward.

James Rosenzweig: We'll, you know, that makes sense. The thing is and indeed the Beers lists of prohibited medications or suggested prohibited medication in nursing homes includes the glyburide right now. The problem is – I think the big problem though is that it's hard to distinguish between different classes of medications when you're setting up a measure like this.

Starlin Haydon-Greatting: Right. This is Starlin again. So in PQA, we did try to test. We're trying to test some of those measures. And in real life it's really hard to tweak this down to look at that by class. So you just have to word it exactly how we

did this and talk about those exclusions criteria so that they understand it's a specific group we're targeting.

Anna McCollister-Slipp: This is Anna. And I have a comment and a question; a couple of comments. One is I like the way that the NQF staff has worded this proposal. Second, just have to say that I'm heartened by CMS's expressed concern about hypoglycemia especially since they refused to cover continuous glucose monitors despite the fact that it would be very cost effective for a large percentage of the population especially those with type one or hypo unaware. (Inaudible) sticking point for patients and huge concerns.

But third, I think this is a reasonable concern. And I like the direction that the American Diabetes Association has gone in recent years. I'm not that familiar with the VA but the ADA has gone towards individualized care and individualized treatment, and that's reflected here care.

I'm wondering if it would make sense, and I don't even know if that's within the roles of NQF. But would it make sense to add some sort of a component of it of less than 8 percent with no significant hypoglycemia or no report to hypoglycemia.

Karen Johnson: Anna, this is Karen. Are you suggesting that as part of the proposed response from the committee? Or are you suggesting that as a recommendation to the developer?

William Golden: You know, that could be – go ahead.

Anna McCollister-Slipp: I'm not completely sure what I'm recommending, I mean whether that's a response from the committee or a recommendations to developer for future development. It seems like it would be a way of addressing when I think of the legitimate concerns expressed by CMS about, you know, that potential for hypoglycemia. But it also acknowledges the fact that, you know, under 8 percent is a reasonable and appropriate goal. I just got – it sort of takes into account, you know – everybody can get below 7 percent if they want, it's just the risk of hypoglycemia. So those two things have to be taken in balance and treatment for – achieving that balance is very much

individualized based on a specific individual's experience with their disease and their life factors.

William Golden: Yes I think that's – you're – putting that into one measure may be complex but there could be a grounds for a hypoglycemia measure in a population that could be paired with this, that would make …

Anna McCollister-Slipp: Right.

William Golden: It could be very useful and informative.

William Taylor: So that would be similar to what we reviewed in the inpatient setting, a potential counterbalancing hypoglycemia measure recommendation to be developed?

Female: I would support that, too.

Male: I support that, too. That's the way to go.

Female: I agree.

Sue Kirkman: I think it's a great idea – so this is Sue Kirkman. I think it's a great idea. The problem is in the outpatient setting, it's very hard to collect hypoglycemia other than severe hypoglycemia. So it may not really be – be that feasible. You know, there's a lot of mild hypoglycemia that's not going to end up in the medical chart.

Anne Leddy: Well, I would – this is Anne Leddy. I would just mention that for most of us, part of every patient visit for follow-up of their diabetes is asking if there have been any hypoglycemic event since their last visit and how severe they are. And at some, you know, future measure, quality measure development, there could be, you know, was the question asked at the visit?

Sue Kirkman: Yes, I agree. I mean I think its – it is often asked but I think it just may end up in a text field somewhere and, you know, it might require, you know, a lot more standardization of electronic medical records and so forth to be able to collect it. So, you know, the inpatient measure, it's pretty easy because you have the data there but, you know, it's going to be a little trickier for an

outpatient measure. But I think it's a great idea because I think, you know, I think there is the lot of hypoglycemia that's just being missed because it's not that easy to collect the data.

(Crosstalk)

Anna McCollister-Slipp: So that under reporting – the under reporting of hypoglycemia has important impacts on a variety of different policy measures from CMS to FDA, and, you know, their lack of focus on that as an important measure for evaluating drug. So maybe this could also be an encouragement building on CMS's or concerns for hypoglycemia. And perhaps this could be an encouragement for them to incorporate outpatient with glucose meter and CGM data. Patients enter a health data in the outpatient setting into electronic health record requirements and meaningful use, which is another big issue that they've not taken on.

William Golden: Yes. I would you suggest that we're getting a little bit detailed, but perhaps we could suggest that we accept the wording of the NQF staff and advise the measure developer that measures regarding hypoglycemia with given several examples, should be reviewed and looked at and considered for future submission.

Male: Good.

Katie Streeter: Well said.

Karen Johnson: Excellent. All right …

James Rosenzweig: I agree. Just to make sure that it's – we already have measures in for inpatients just make sure we mention this at the outpatient …

Anne Leddy: We have a measure for patients in the hospital developing hypoglycemia, but there is no measure for admission to hospital with hypoglycemia.

William Golden: Or ER or something, yes.

Anne Leddy: Or ER. And in fact that is one of the points made in the post cycle comment.

Robert Bailey: And in this Bob …

Sue Kirkman: But the impact of hypoglycemia goes way beyond ER in severe hypo. I mean …

(Crosstalk)

Anne Leddy: Oh sure.

Sue Kirkman: … a significant impact on quality of life and ability to function. So, I think it would make sense, you know, whether it's through the context of this measure or if there's a separate measure that we need to start incentivizing physicians generally to think carefully about, you know, how to manage patients or help patients manage their disease without (inaudible) without hypo. And reporting that in some way would probably be an incredibly important goal or part of the process that we need to make that happen.

Robert Bailey: And I'd also recommend that we incorporate developer's comment there in terms of calling out the exclusion criteria or highlighting that as well.

William Golden: Right.

Karen Johnson: OK. Anybody else had any final words on this issue?

Starlin Haydon-Greatting: This is Starlin. I just want to let folks know that at the (HCPCS) or (HMS), depending on what you call the computer geeks in health care, they just had their meeting here in Illinois, and one of the interoperability topic is how all the different EMR systems and physician's offices and hospitals can start taking downloads of blood glucose information off of the meters or off of the CGM. And they are trying to work with that group to standardize because every meter company has their own way of downloading the reader information and for an EMR, they can't have 27 different ways. And so they are – it is on the radar, we just have to get some of the propriety systems to get standardized.

Sue Kirkman: (Pain in the back).

Starlin Haydon-Greatting: Yes.

Male: (Both times).

Karen Johnson: I think.

William Golden: Shall we move on to the next item?

Karen Johnson: Yes. So, the next item, it was a couple of comments that came through, basically that were critical off the composite measure. The concern being that if you are using a composite measure, you might mask the individual care processes that folks would need to work on to improve.

So, the developer also provided a response to that. And if you'll go to the next page, Kaitlynn. And we, as NQF staff, drafted a proposed committee response for you guys. So maybe you can just discuss that, take a peek at the response. It's on your screen, and Jamie, I guess would you like to facilitate this discussion.

James Rosenzweig: Sure. This was also something that we discussed at length during our previous meeting. The idea that just one particular component may have a big effect on whether not a composite measure is achieved or not since there so many different components. Perhaps, you know, there could be a – people could be concerned about the measure being counted to basically as a punishment, let's say to individual plans or to individual providers.

James Dudl: This is Jim. I think we covered this well last time. Individual components are very important in and of themselves. But sometimes when you get to fairly high levels of individual component use, putting the whole thing together still shows you a real opportunity and by finding out which parts of it are not working well, gives you a great opportunity. When we start getting to the 88th percentiles of most of the components, there is a little take your foot off the gas on the individual. But the total was only 50 percent. And we say "Wait a minute, that's really not adequate." I think that – I think both have value and by collecting the components and the total picture, it gives them opportunities.

James Rosenzweig: I agree with that. I think we – the issue we discussed a lot at the last meeting was the issue of the tobacco measure, having, you know, being that particular measure, having less of the chance of the physician actually having an input on improvement for that particular measurement. And I think we've covered it fairly well at the last meeting. I see no problem with the proposed measures, so.

Karen Johnson: So, I'm not hearing any – what I'm hearing is everybody feels comfortable with your discussion that you did in the last time. Would anybody have any changes to make to this proposed response, any additions or modification?

William Taylor: This is Bill Taylor. I was uncomfortable with this before, I'm still uncomfortable with it. I think we did talk about it enough. I think I was outvoted so I'm not sure there's any point in having the same discussion again. But in terms of how comfortable we are, at least, I wanted to say that.

Karen Johnson: Thanks, Bill. OK, I'm not hearing any major concerns about that committee response. So, we'll go on. The next comment really had to so with a concern that you can't figure out greater than 8 percent and less than 9 using CPT codes. And the developer responded to this, you can see their responses, but basically the response was that the measure actually doesn't even use CPT code. So just a reminder, this was based out on electronic health record. So, really unless you guys as the committee wants to discuss anything regarding the CPT coding, there is no committee response for this portion of the comment.

OK? A couple of more comments also suggested a need for adjusting for sociodemographic factors in the risk approach. And again, we opened this up to developer response. And basically they say our risk adjustment model. Those include insurance product which is a proxy for socioeconomic status. And that was discussed by – (Sid) discussed this the last time. I did not do a proposed committee response for this but if you guys think that you want to make a response, we can certainly draft something and put that out as a committee response to this comment. Does anyone on the committee feel like you want to respond as a committee to this comment or do you want to just let the developer respond (inaudible) matter?

James Dudl: This is Jim. We have found in relationship to adherence to a blood pressure meds, lipids, and A1C, a major difference in African-American and Hispanics across the board. It's 10 percent, it's very significant, it's important. When we look at our White and Asian population, we're at the 98th percentile. When we add them in, we're in the 75th.

There's, I think, a reason to consider it, especially since there's really a hit in difference in adherence and you can approach adherence. However, that said, that's hard to do and I think what the developer said is a good proxy and a good start. I guess I would lobby for as looking at breaking it up in the future. I'm not sure I would change the comments or.

Sue Kirkman: So the other thing -- this is Sue Kirkman -- and maybe the NQF staff can speak to this, but you also don't want to sort of get to the point where you're adjusting away, you know, higher risk people. You know, I mean blood pressure control is really important and, you know, African-Americans have much higher rates of diabetic, kidney disease, for example. So you wouldn't want to sort of adjust so that, you know, the goals were sort of less stringent for African-Americans.

James Dudl: Great.

Karen Johnson: And so, this is Karen. I'll make one comment and then maybe pass it on to Collette. But just in case you aren't aware, NQF had actually reversed its (stance) on adjustment for sociodemographic factors in general at one point, until very recently actually. We actually did prohibit adjustments of these kinds of factors in this model for exactly the concern that Sue mentioned.

And last summer, we pulled together a committee of expert methodologists as well as folks who are very well-steeped in disparities research. And their recommendations that NQF has for the most part accepted is that sociodemographic factors and risks adjustment models should be treated just like any other clinical factor. And basically that means before you think about using it, there should be a conceptual basis for thinking that it might be important and then look at it empirically to see if is important, and then you make your decisions in your modeling going forward from that.

There is, of course, a big problem and that is availability of data. So there's probably conceptual reasons for a lot of things impacting these kinds of measures but the data often aren't available. And, you know, you might not be able to use some of those things in risk adjustment models to the present just because of that data availability problem.

But we are, at NQF, now accepting risk models that have this. We are starting what we're calling a trial. Basically, we're going to let this run for a couple of years and see what the impact is. And there's plenty of information out there right now and more forthcoming very soon about what's that's going to look like and things for committees have to consider.

But, all of that said, Collette, I hope I'm not putting you on the spot, but if I recall from your measure and I apologize I didn't look at it real closely before this call, but I think you guys actually did look at race in this model and it actually was not a specifically significant actor in the models that you guys developed. Am I correct?

Collette Pitzen: Thanks, Karen. This is Collette. I'm scrambling through my paperwork but we do have a process where we actually are collecting patient level information across all the clinics in Minnesota to calculate these measures. And as part of that process, we are running variables through our risk adjustment models.

So the risks adjustment variables that we have for this measure, insurance product, age band, and diabetes type 1 or type 2 did come out statistically with the P values beyond the range of negative two to positive two. So those were the variables that have been selected.

But we're continually evaluating. We're collecting race, ethnicity, and (linkage). We've actually gone through a five-year process of ensuring that groups are performing best practices in collecting that data, and we do health care disparities report that has shown some disparities between races among the diabetes population in this measure. But those variables are, you know, subject to future evaluation in terms of impact. But for right now, the ones

that are in the model are the ones that were showing the potential to be good risk adjustment variables.

Karen Johnson: So thank you for that. So if I could paraphrase this real quickly, I think I heard you say that you're continually looking at this. So as more data come in and as you go on, you actually relocate your risks adjustment models on a fairly regular basis.

Collette Pitzen: That is correct.

Karen Johnson: OK.

Starlin Haydon-Greatting: This is Starlin. Could you add that information to the response?

Karen Johnson: As the developer?

Starlin Haydon-Greatting: As a developer, yes.

William Golden: Developer, yes.

Collette Pitzen: Sure. I can work with (staff) to add that.

Karen Johnson: OK. So I didn't hear from the committee that you feel like that you need an additional committee response. Let me open that up again just to make sure. Would anybody like to see a committee response on the SES or we're just going to leave the developer response to standalone?

Collette Pitzen: Could we say that we agree with the developer's response, or is that just not necessary?

Karen Johnson: We can say that.

William Golden: Yes. You may want to also make some comments about the NQF's engagement with the whole issue of disparity adjustment, you know, sent to on that regard as well.

Starlin Haydon-Greatting: Yes, this is Starlin, I agree with that. That way it shows that a process has been broadened.

Karen Johnson: OK. So …

Janice Miller: I agree. It also – this is Janice. I think it will also fend off a lot of other future comments if there is some dialogs, that it's something that NQF is developing.

Karen Johnson: OK. We will do that. And then the final comment had to do with a suggestion for additional detail regarding moderate or high intensity therapy for the statin use component of the measure. The developer provided a response there. You can see that in front of you. And this one is another one that I did not provide a committee, a draft committee response. So, if you guys would like to – maybe Collette, you can just recap your response there and then the committee can decide if you think that you want have a committee response, we can create one.

Collette Pitzen: Thanks, Karen. I'd be happy to. We've actually gone through a real thorough redesign process. The cholesterol component of this measure previously was LDL less than 100. And we went through a yearlong process with our measure development group following the new ACC/AHA guidelines.

Initially, we had a strategy that did include specifying the dose, either a moderate or high intensity statin. We had a ton of discussion around that particular thing, especially for the diabetic population part of that determination for dose between moderate or high involves use of the CV risk calculator.

So a lot of the things that said in our decision to not specify a dose, included data burden for the practices, the controversy, and the burden surrounding the CV risk calculator. Our (exceed) diabetes guidelines recommendations for measurement did not include those. And actually the cardiologists and her workgroup felt that there was benefit for some patients who could only tolerate a lower intensity dose of statin. So for all of those reasons, we decided to specify the numerator compliance for this component to be you're on a statin and not specifying the moderate or high intensity dose. But we can appreciate the commenter's comments.

Sue Kirkman: I think that's …

(Crosstalk)

William Golden: You know, if we had concerns about people with limited life span, this would also come into play there as we'll. I think the complexity of trying to be tailored here would be daunting through all sorts of folks.

Sue Kirkman: Yes, I think it's a very reasonable response. I think it's still a measure of evidence-based, high quality care, just as, you know, just to show that someone is on a statin as opposed to getting so granular.

Karen Johnson: Is there any desire to draft a response from the committee on this issue?

OK, hearing no more on that, I think we're not. So just to recap what we're going to do, we are going to add in a little bit more to the proposed committee response about the comments from – regarding the National Action Plan to talk about the exceptions that actually are included in the measure.

For the composite measure itself, I believe you guys were good with that response towards the HbA1c. You didn't have a response that you wanted to do, but for the SES trial, for the SES comment, I will create a committee response, just noting your agreement but also talking just a little bit about NQF and some SES inclusions of SES factors in this model. And then finally, we will not have a committee response directly to the comments regarding moderate or high intensity statin use.

So that completes that portion of the call. So thank you very much. We had you guys – just so you know what's going on and maybe I should leave it open but my interpretation of your discussion is that everybody is still pretty much happy with the way that you voted the last time, and there is not any appetite from the committee to revote this measure.

(Crosstalk)

Male: Sound good to me.

Karen Johnson: OK, it's good. It's good. All right, so for the next piece of the call, what we wanted to do is to basically take advantage of you guys being on the phone

with us to get a little bit of feedback from you about your experience thus far on our endocrine standing committee. So let me give you a little background as to why I'm asking this question.

Typically at NQF, what we have done in the past is we – depending on funding, we generally looked at measures in a project, for example cancer or perinatal or endocrine or neurology, whatever, roughly about every three years. And that sometimes works out but sometimes it doesn't always work out for measure developers because they have their own time frames going on. And sometimes they might have a measure that they're are almost ready to submit but they don't quite make our deadlines, and then they may have to wait three more years before they can bring it to NQF.

So, there response from NQF was to do a pilot of what were calling more frequent submission and evaluations measures. And basically, the endocrine project was selected to be the pilot for that. And what we did is a little bit longer project than we usually had, it's the total of 22 months. And over that 22 months time period, whether you're just having one big meeting where we look at all the measures that come in for that time, we actually split it up into what we called (inaudible) three cycles that we work together on with you.

So just to give you a little reminder, cycle one, you guys were first (seated) and you were our first standing committee, and you look at 17 others (inaudible) and you may …

Katie Streeter: Can everybody mute their phone, please?

Karen Johnson: We did do workgroup calls in that first cycle because this was new to most of you, I believe. So we did the workgroup calls and discuss the measures and discuss their criteria and discuss their process, et cetera and we did all of that before you came to the in-person meeting.

And one thing that we did provide at that point was what we were calling staff reviews which was some high level summaries of the submission. And there was some related and competing measure discussions back in the midst of time that the related competing discussion that you had for cycle one had to do with the blood glucose measure. There's a poor control, a good control

measure, and then there was a measure just for testing. So you talked about whether there was a need for the testing to measure given that you have those, you know, immediate clinical outcome measures.

And then for cycle two, roughly six months later, we only had six measures for you to discuss. So, you know, really wasn't a backlog of measures for endocrine actually to come through. So the six measures were maintenance measures. Some of those were actually left over from cycle one. They would have gone down and not been endorsed by the committee in cycle one, but the developer ended up withdrawing them. They were the foot measures from the podiatry folks. But they brought them back in cycle two. They cleaned up their specifications and you guys did recommend them for endorsement.

And then there were also several related competing issues because most of that (towards) the six measures that you discussed cycle two were osteoporosis measures. So there were a lot of issues of harmonization that you guys tackled in that cycle. And then finally, cycle three is the one that we're on now, and there's, as you know, two measures. And these two actually were pushed off to cycle three on purpose just because of the guidelines being new and having to developer's time to modify their measures to conform to the new guidelines. And the related competing issues that you discussed at that point had to deal with the need – yes or no of both the composite measures and to the individual measure. And you guys talked about that even more on the call today.

So what we would like to get from you after I've reminded you of you of all the work that you've done with us in last several month, we actually would like to get your feedback on how you thought these business of doing things roughly every six months, how that works for you? So, we've given you in your -- if you can go down a little bit -- in your memo, some of the items that we would like for you to respond – she's going to bring that back in a minute. But this isn't – if you think of other of pieces of feedback you'd like to give us, that would be great. But we're interested in things like, you know, did you think that an every six months evaluation is too frequent?

Obviously, we had to pull you together for a lot more meetings than we would have, (we'd done it just once). And I neglected to mention that cycle two and cycle three obviously were not in-person meetings. So you got to experience doing in-perons meetings and web meetings and how do you think that's (inaudible).

So I think – let me stop now. I'm not sure what happened with our screen. They're trying to get that back. But let me stop now and just open it up to see if anybody had a feedback about how you think this went. Did you love it? Did you hate it? Do you have ideas as how it could have been better? Does anybody have anything to say?

Sue Kirkman: So, this is Sue Kirkman. I am – my only comment is that six months in a way seems like a long time because I know that, you know, by the time the next cycle rolled around, there was a lot I had forgotten about the process and so forth.

Karen Johnson: OK.

Sue Kirkman: So, I don't really know how to get around that but – and I don't know if anybody else felt that way. But, yes, I sort of feel like I had to relearn it.

Karen Johnson: OK.

Janet Sullivan: This is Jessie. I would agree with that. On the other hand, I really think it's valuable to have the opportunity to update measures more frequently. And I was just thinking about our discussion today about the new AADE report that just came out and our recommendations that people look at counterbalancing hypoglycemic measures. And, you know, I think it's an unresponsive system that can't adjust, you know, even in theory, has no way to adjust in that shorter time period than three years. So, I think the idea of being able to review measures every six months is a good one for what the NQF ought to be doing.

I do agree that – I felt that we probably paid more attention to what we were doing when we we're doing it in-person and that maybe – I know it's too expensive to bring people together in person every time, but maybe some kind of little refresher when we reconvened would have been helpful.

Karen Johnson: So that's actually very interesting. And let me just – Jessie and Sue, are you talking about like the refresher on our criteria, on our process, or just on all of the above?

Janet Sullivan: I think almost on all of the above, you know, just kind of – because I think when we did the it the first time, we were all very, very intent on it and then we met in-person. And so I think we really, you know, had a good grasp on it. And then coming back a little later, it's not in-person, it's been a while. I think sort of a little refresher about the whole thing might have been good.

Karen Johnson: OK.

(Crosstalk)

Robert Bailey: This is Bob Bailey. I guess my comment would be a three-year time frame for review is too long especially in an era where evidence is being generated at a more rapid pace and being incorporated into clinical guidelines more frequently. So the frequency that we have here every six months seems to be a better frequency than waiting for every three years.

Starlin Haydon-Greatting: Yes. This is Starlin. I agree with Bob. I mean we're – every week we're getting a new update on something, and I really like how our committee was able to stay on top of things. And I feel that that serves the people better in the long run.

Ingrid Duva: This is Ingrid Duva. I just wanted to say, I really did appreciate the in-person meeting and when we were sort of more rigorous going through the parts of the process. Though, one thing that's been – and I do like that we are meeting at a six month basis so that it's more frequent for the measures to come up also. But it's also nice if we have less measures that we're discussing at one time, because it gets – I think it is important to get sometimes to get into the sort of (minutiae) discussions at times and you can't do that when you have so many measures at one time.

Anne Leddy: This is Anne Leddy. Just going through all the questions, my opinion is that an every six months is reasonable frequency. I would encourage the number of measures at a reasonable level, five or six at time rather than 15 or 16.

I have no comment about the overlap. I really need the staff input here. I thought the initial in-person meeting was valuable. It was really great having time with the staff, meeting other committee members. And we we're all starting at the bottom of the learning curve. As time went on, the ease of discussion got better. It certainly developed with experience for me. I've had no fatigue about it. It's a dynamic interesting process.

I think telephone contact tutorials in the beginning are very helpful. They're not as necessary as time goes on. I would like to have the schedule four to six months out. That would be helpful, but there will always be conflicts in such a large committee. And I do think frequent portfolio review is merited. I propose these studies that appear report such as the National Action Plan for Adverse – Drug Event Prevention, I mean huge. And as for the next committee, I would ask CMS to present a proposal for quality measures to prevent hypoglycemia, at least seek proposals from other developers as well.

(Crosstalk)

William Golden: You know, one question, a subtext to your question is are the developers and the developer community geared up themselves to take advantage of a more responsive and flexible system those committee could represent to them?

Karen Johnson: You know and just from the NQF staff side, you know, I think it probably depends on the topic area. So what we saw it the last several months with endocrine is that there unfortunately doesn't seem to be a lot going on by developers in this area; so, you know, that backlog if you will.

So basically, having the more frequent opportunities to submit, I don't think it was actually that helpful for developers for endocrine measures because it lessens the backlog. I think it was helpful was for the podiatry developer and their measures because, otherwise, you know, at the end of cycle one, their measures would have been – they would have gone down. And then they would not be able to bring that back to us for, you know, three years but they

were able to bring it back, you know, in few months. So to that extent, the developers, you know, did benefit from the pilot.

William Golden: Let me course my comment a little differently.

Karen Johnson: OK.

William Golden: So you have new measures but then you would have revisions to existing measures because of a change in (science days). I guess that kind of links up to pervious comments from the last speaker or two.

Karen Johnson: Right. So let me clarify and it's something that we may have mentioned to you way back at the very beginning, but maybe not because it isn't always applicable. But we have this process that we call our ad hoc review process. So basically, if the science changes, you know, some new city comes out and just changes everything, or new guidelines come out and things are changed, we actually have a process outside our regular project work that we call the ad hoc review process where we – anybody could ask for an ad hoc review of any measure based on some kind of change in science or actually off of based on unintended consequences if something is being shown, if there's something really not working out right because of the measure.

So that could happen at anytime. It doesn't require having a project. It actually is getting a little easier now that we have standing committees because we used to have to pool together in a short period of time, some folks that would be able to serve on our ad hoc committee is kind of a one-off thing. But now if somebody asks for ad hoc of one of our endocrine measures, you guys are standing right now so we could bring that to you almost immediately. I mean obviously we have to schedule some time with everybody, but we would be able to do that.

So in terms of you know the science changing, this every six months change is helpful but it's not necessary because we had another way to deal with things there. What we didn't have another way to deal with was the brand new measures that they wanted to bring in or, you know, also whatever reason, they're in the middle of reviving a measure and their time line just doesn't

mesh with others. So, you know, having a more frequent option would help in that scenario.

I'll tell you what we were thinking in terms of overlap of cycles, and it sounds like it's not a problem for you guys at all. Even a little bit tough for us as staff because at the end of cycle one, we were still doing things – and Jamie and Bill, this may – you guys would be the ones on the committee that would be affected. But we were still doing things like a public – we're not so much public commenting but voting and going to CSAC and the board so that, you know, (staff) process steps. And in case you guys, didn't know, Jamie and Bill actually do come to our CSAC meetings and present the results from your deliberations to our CSAC. So that was going on for us at the end of cycle one at the same time that we were getting things ready to hand off to you guys for review cycle two.

So, just here internally, we were getting a little bit confused because we were trying to finalize measures from cycle one and also having our minds in measures in cycle two. So, I guess that overlap of cycle is more of a (SES) thing unless Bill or Jamie had anything to add on that. Was it confusing or are the schedule for you guys to do CSAC with us and look at the memo? Isn't that sort of thing and but also do cycle two.

William Golden: It was a little hectic but we managed, yes.

James Rosenzweig: Yes, I didn't find any major problem with that. The only issue might come up is it – is a six-month period time enough to be able to complete the, you know, all of the processes related to getting a measures approved and (enable to) come back for the committee for revision and things from staff perspective.

Karen Johnson: It's a – on a full process, basically we – our calendar starts – we usually start zero time or time zero as the end of the submission date. So we ask developers to get things to us by certain date. And then the time frame from that date to the actual board decision of endorsement is about seven to eight months, I think, something like that. Is that right, Katie?

So that process there, the six month cycle that we have here, you know, there will always be an overlap there. But then part of – when things do start up or (inaudible) startup have to do with their funding and with time frames that were given there. So, I think sometimes it's going to be worse than other times just because of the time lines that are outside our control.

Anna McCollister-Slipp: This is Anna. And just giving comments on the point, the bullet points here and their particular order. In terms of frequency, I think six months made sense to me, I think, you know to – not to reiterate all the points somebody else already made, but there's a lot of data that's coming in. I think it's important to have a regular cycle, an opportunity for people to submit measures. And I like the fact that people can adjust or change them and then resubmit them as needed.

I've liked the in-person meeting. I thought that was really helpful. And it was certainly nice to meet everybody and sort of put a face to the name and get a sense of the individual making comments. I'm a little different than most people in this, but I'm, you know, a five-minute cab right away from NQF so I don't have to fly in from other parts of the country but – so that's less of a burden for me. I think the online calls are fine, but, you know, I think in person generally convene more productive in some respects.

One thing that I think would be helpful and perhaps this is the because I'm a patient and I'm not – I don't treat people, you know, I'm a not a clinician, I don't treat people, I don't see people except for cocktail parties when everybody asks me the test of blood sugar or something, but I think sometimes one thing that I'm struggling with is context and how – what each of these measures mean and sort of the full suite of measures, what that implication means for the individual physician. I mean I know what happens when I go in to see my physician. I also know that I'm really lucky and have physicians who spend like an hour with me, even though they're probably not getting reimbursed for anything close to an hour.

So, one of the things that I'm cognizant of is the fact that we have a shortage of endocrinologist, and that if we add burdens to their lives, even though it's, you know, these are the important things that need to be done for everybody,

we just sort of to think about, you know, know can we either harmonize the measures and I know that's important for the committee. But it's very difficult for me to say, you know, yes endocrinologists you need to do all of these reporting factors. It seems like we'll be relatively straight forward to pull the data from the EHR because all of these fields are required in HER. But I'm not running in endocrinology practice.

So I think it would be helpful to have an understanding and how all of this fits in. And again, maybe I'm just an outlier here and everybody else gets it. And we certainly don't need to tailor the committee's activities to me. But that's one thing that I found to be somewhat that I struggled with a bit in trying to evaluate the measures.

In addition, one that thing that I've found a little frustrating and perhaps this is just completely outside of the (agreement) of this committee is that I feel like there are a lot of incredibly smart, insightful people in this committee. And part of what I think would be helpful is that the committee could recommend (needs) for measure as opposed to just proposed one. Maybe NQF has an entirely different process for doing that. Perhaps this is something that CMS asks for. I don't really understand how the specific measures get requested and developed. But I think, you know, whether the hypoglycemia discussion we had today, or, you know, other thought that this committee might have about what might be important indicative of quality of care, I feel like there needs to be a process by which that's taken into consideration. And again maybe it just the issue that I don't understand all of the processes that go on elsewhere at NQF, and, you know, maybe that's just, you know, my issue. But it's seems like there's a wealth of knowledge and a wealth of perspective that could be used (and tapped).

I remember, at the in-person meeting, I believe it was Helen Burstin said something about they're being measure's incubator at NQF. That was beginning. I don't know where that stands. It would be interesting to find out. But, anyway, those are sort of my comments.

Karen Johnson: Thank you, Anna. Anybody else? Any feedback?

Claudia Shwide-Slavin: Yes. This is Claudia. I was trying to unmute my phone, sorry. I just wanted to add one thing to what Anna had to say about being more involved pipeline development. I think that was something that really caught my ear in our first meeting and I agreed with what everyone said about the live meetings in the six months frequency and all of that, and the education.

But to knows that there is a pipeline and not to really know the process of how something enters the pipeline and to be able to do grassroots work to get things into the pipelines, like in the field of education, let's say, and I'm sure there are many other areas that people would want to have measure than to the pipeline. So, that's something I think that could be developed.

Karen Johnson: And this is Karen. Let me – like you're suggesting that this could be (potential) role for the standing committee to help encourage developments and submissions to NQF? Do I understand you correctly?

Claudia Shwide-Slavin: I don't know if this committee or as a side project from this committee and that – but think this committee needs educated more about what that process is, and possibly give opinions on how to build an education around that because I don't think it is really well known. I know AADE had no idea about the fact that a pipeline did exist and how to start submitting education topics for consideration and I'm sure they're not alone.

Karen Johnson: I see. Thank you.

Anna McCollister-Slipp: Yes. And I – I mean this Anna again, and I talked with other researchers that I know who are very well-known endocrinologists and researchers who had no idea that this process was on going. So, I still like, you know, by the best – communications or an outreach issue or whether that's something that the staff has taken into consideration. I do think that there's a lot of really helpful prospective that could be garnered from this committee, and again, maybe there are other better processes for initiating these kinds of things but it would seem helpful.

Janet Sullivan: This is Jessie. I had a similar experience (inaudible) meeting and there was a representative from the Podiatry Association who had not been involved in presenting their measures. And he was very interested in knowing what the

committee would like to see in a (quick) measure. And I wasn't if I was OK for me to discuss that with him, but it seems like it would a helpful output for the committee to say what, you know, what we didn't like and what we risk with seeing in some of the measures that we discussed.

Starlin Haydon-Greatting: This is Starlin. I always saw our physicians on this committee also as an advocacy and an ambassadorship on educating our peers in this process and how important this process is. So if I would drill that in into the committee prior your selection and committee process and maybe create, you know, a stack speech where we know the do's and don'ts of what we answer, what we refer to you.

In the pharmacy, I'm one of the few pharmacists that sits on this – on your national committee. So, I've been asked a lot of how do we get more involved questions. Now, I'm also part of the Pharmacy Quality Alliance. And so that group is very harmonious with NQF. And so that's not the problem, but just like with AADE, they didn't really know whole background – I'm also part of the AADE because I'm a diabetes educator. But I do see us kind of as an ambassadors and helping educate our colleagues and peers about why it's important that we have these measures. And why it's important in these pay per performance world that they have good representations that it's just not somebody – because a lot of people just believes somebody just decided to do this. And they made the role and they turned and everybody has to follow. And when you start explaining that it's a very involved scientific process that has lots of conscientious professionals lay people that, you know, like Anna that contribute well, they soften up and then they are more considerate of what this has to do for population management.

So I benefited a lot from being part of this program. I love the in person. I'm a motivational intervention person, so I know some face to face is necessary to pair with telecommunication. So getting to meet each of you in person was very valuable to me. And also, I've read most of the, what I call rock stars, Dr. Dudl's papers and getting to meet him in person was quite a thrill for me. But I mean – and that's what I carried out. I've tried to explain to people that, you know, the government is just a big brother trying to tell you what to do things. The government comes to NQF and has NQF review their measures

and I really do. The advocacy or education about the measure of pipeline, I think it's really important for NQF to kind of ramp that up. And all the other comments that everybody gave I agree with as well.

James Rosenzweig: I think I maybe in disagreement about this particular point. I think, functionally as a committee, we are really – we really should focus on being able evaluate and recommend for approval measures that comes to us, you know. We're the kind of final common pathway for these measures or at least the NQF is. So, if we were to actually get involved in development of measures, I think that would be kind of an extension of our own function, our own committee to other areas.

I think if the NFQ wants to get involved in it, then that's great. And we could provide input to whatever organizations within the NQF that would be responsible for advocacy. But we have a lot on our plate, you know, with our current committee, and we should strive to do as best as possible what comes to us.

Now, the other thing is that, you know, we have talked in past about wanting to get involved with or being wanting to actually review a lot of other endocrine measures for endocrinologist in areas that are other than diabetes and osteoporosis. Well, I've been involved in work and trying to develop measures with the endocrine society. And the fact is right now, things are kind of on hold because there's no one requesting new measures from us. And lot of the measures sets that we were working on were to be – were basically to have – to be involved with the American Board of Internal Medicine's maintenance certification. And that's all on hold right now until they review – they were kind of backstepping it and being able – to try to reassess how much measurement they actually want to do of individual physician's practices.

So I would argue that you know we should not try to expand our role too much beyond what it currently is because we enough on our plate.

Female: So I just want to clarify that …

(Crosstalk)

Claudia Shwide-Slavin: … but I think we need to know. We need to know what it is – what's the process or something that goes into the pipeline to comment on that. And I think there needs to be somewhere, something going on in relation to pipeline education. I didn't necessarily think that it was our committee that should do it because I agree with you. I think that we have plenty on our plates to deal with. But that was just a comment that I had coming out of this experience.

Robert Bailey: And I think one other important consideration here is if we get involved in the development, then we lose the objectivity in terms of evaluating it against – the quality measure that come through by this criteria.

Starlin Haydon-Greatting: This is Starlin. I don't think we should be involved in development either. I was reaching out to the fact that we're kind of advocates for the NQF. And I do think there needs to be a line of delineation. And I do agree with the staff point for the last review before the measure goes out to the vote. So – but I do think …

Anna McCollister-Slipp: This is Anna since I'm the one who started this discussion about measure development and recommendation. I don't know exactly what – I mean I don't know exactly what we mean by measure development or making recommendation for development. And what I was – specifically, what I was referring to is the fact that there's seemed to be – I mean that this point, we're just reactive and maybe that's appropriate, and perhaps this issue is something that just doesn't need to be before this committee. But I don't understand the process, and again perhaps this is just my ignorance, but I don't understand the process by which specific measures are sought and recommended. I know that there are different groups that submit measures. My understanding is that those measure developers are solicited by NQF in response to a request from CMS. That could be completely, completely incorrect.

And my thought is as a patient, that there are a number of measures that matter to patient that probably aren't reflected in this process. And I think the hypoglycemia discussion we had earlier today, you know, is in fact was arranged by CMS oddly enough is really important. You know, being able to

recommend or have patients come and recommend the development of measures, I think would be critical if there's some sort of a process for doing that or clinical or community physicians that there's a mechanism by which they could do that some sort of petition. I don't know.

But also, you know, for instance, in the discussion we have last time and I remember this because I raised the issue around reporting of adverse events for statin, and that was just an issue, but I was aware because that was something that my mother had experienced twice because the doctor was trying to adhere to good clinical guidelines around treatment of people with type 2 diabetes, where she had severe reactions to statins and, you know, there's no – making recommendation to use a drug is one thing, but helping physicians understand that they also need to follow up and make sure that there are no adverse events or something different.

And I think those kinds of recommendations and discussions that we have as part of the committee, I don't know if they go anywhere or what happens to them afterwards and perhaps nothing happened. But there needs to be a mechanism by which the wisdom of this committee or some of the body is taken into account if they really want quality measures to be respective of what diabetes community, particularly, as a patient and other – representing other patients from this committee, you know, I'm not sure that these measure is necessarily reflect what patients would consider a high quality.

Janice Miller: This is Janice. I believe that this committee has a lot of collective wisdom and experience. And when we look at this, I don't think that we are in a role to actually do any measure development and I think that's beyond the scope of this committee. But I do think that this group individually collectively knows what components of care are really important to be able to improve care and to improve outcomes. And in order to be able to accomplish some of these things, some of them need to be tied to reimbursement. And obviously a lot of things that we do to that end to improve outcomes are not reimbursed.

So I think one of the things that this committee can do is to make recommendations for new measures for development. And, you know, I don't want to be a one hit wonder like these teen pop bands but about diabetes

education but as an example. But if we say that something like that is going to be measured and that practices are going to be reimburse for them. I think if that is something that is really going to drive overall improvement when there is reimbursement attached to the measurement, we know that there is improved behavior.

So I think that the role of this committee as far as pipeline and development is that we know the components that improve care and outcomes. And if we can identify them and be able to suggest measures for development for this incubator, I think that we really are in potential – in a role to really potentially improve outcomes and care.

Karen Johnson: Great. Well, this has been some good feedback and discussions. And I should probably just make sure – I think you guys are – you're definitely right and you may remember that in our in-person meeting, we actually did have a pretty long conversation about gaps and, you know, new ideas for future development and – that actually has a pretty prominent place in the report that they we wrote from that meeting.

We have been an unable to do that level of discussion about, you know, potential ideas – ideas for potential development in our other meetings to some extent because, you know, two-hour web meeting go really fast. But even that said, we have included – when they come up in conversation, we have included those kinds of things in the report. But I think that might be more an easy thing.

As Katie said, you know our official, official work you guys is kind of coming to an end relatively soon, but you guys are still part of our standing committee. So even though we don't funded work to do, we may do some NQF-funded stuff with you and I think one thing might be a call just to review the portfolio, talk about gasp. You know, we don't necessarily want to do the same things that we've already done. But if you have ideas about, you know, how we can structure that discussion, we don't want to waste your time but we also would like to keep this committee alive and let you, you know, make comments and that sort of thing, you know, at least for the foreseeable future.

We're a little bit unsure about how funding works. Again, just so you know, right now, the way is funding works is we're giving funds for project-specific work. So we were given money to do endocrine. And we basically have done endocrine now pretty much. We've got another, what, three or four months to process this project. This time, you know, it goes at to those and goes to CSAC, goes to the board, has a chance for appeal, and there's a final report.

So, you know, there's still quite a bit left. But I think there is still, you know, some options I think to draw in your collective (wisdom). So that's what that last item there, your ideas about what might we meant.

Vicky Ducworth: Hi. This is Vicky Ducworth and I'd like to make a comment, too. I know throughout this time, we've had a lot of discussion around unintended consequences. And I wanted to share just one that I think you maybe interested in. You know, I didn't participate in a lot of conversation especially when we started talking about the clinical pieces. You know, I'm not clinician, but the – I think NQF, you guys did a really good job teeing this up and how we considered these metrics. And I was able to take lot of that back and guide my teams in the same type of process as we designed some our alternative key models.

You know, we do a lot of work in this (fields) and we're spending a lot of time designing them. And we really have kind of used your process as far considering the validity of our metrics as it relates to our ultimate goals of (ECU), as well as the feasibility. We were able to incorporate a lot of designs for activity and reducing administrative complexities and flow rate for the individual providers that we knew would be participating in our ACOs.

So actually, a lot of what you all have are really good tools, I think, that could be shared with others in our community who designed these types of models. And so, thank you for that and this experience.

Karen Johnson: Well, thank you. That's (inaudible) to hear that people are using our thinking.

Vicky Ducworth: Yes, that's good. I'm not saying our designs are completely, you know, wonderful as far as the (inaudible) complexity go, but we're being very sensitive to that and all ultimately, you know, that's goal to really create, you

know, efficient and (fiscally) viable and sustainable model. So, that was helpful.

Karen Johnson: Thanks.

Vicky Ducworth: Sure.

Starlin Haydon-Greatting: This is Starlin and I agree with Vicky. And when the Pharmacy call the alliance was going back to restructure their process, I don't know – I don't know, (Julie) or (Lynn) called you guys, but I sat in on a focus group and described how well your processors are put together so that it – you know, we're looking at specs and evidence, and it eliminates a lot of – well, this causes confusions in some cases but it also allows you to have a working thought process from beginning to end. And then when it comes back with the comments, then we're more sure that we, how we've got to that decision and that's invaluable. So, thank you.

Karen Johnson: Thanks. So, one more question that I'm almost afraid to ask but I'm going to ask it anyway. We do write up your discussions. We have a kind of a front matter report, kind of general process and stuff. And then in the appendix, we try to summarize to the extent that we can, knowing that you guys get into really a detailed nuances. But we do try to describe what happened in the meeting and summarize some of the main points.

I'm just curious if you guys as the committee, do you look at those reports that we write of your discussion? Or is that something that – I know we've made them available but I don't know that we've called your attention to them and actually requested that you take a good hard look at those and some just curious that anybody actually reads those. And it's OK to say no If you don't.

(Crosstalk)

Starlin Haydon-Greatting: This is Starlin. I read it and keep up my on what we previously went over. I used as like minute so, OK.

Karen Johnson: OK, great.

Sue Kirkman: Personally, I didn't know that was available.

Karen Johnson: OK.

Sue Kirkman: I'm embarrassed to admit it.

Karen Johnson: No, we're embarrassed for not making sure that everybody realized.

Janet Sullivan: This is Jessie. I found it recently and (reviewing) more recent one.

Karen Johnson: OK. Great. Yes, they're a little tricky to write because our audiences, we don't have one audience, we have a lot of audiences so we try to not get too technical and choosy but, you know, sometimes, especially some other statistical stuff can be a little tricky, the medical stuff, if you're not clinician, can be tricky.

All right. Well, we don't need to prolong this so if – let me give you another second activity, if anybody has anything else burning that you want us to know?

William Golden: You might give us the clue as to when we might hear from you all again.

Karen Johnson: Oh, that's a good, a question, Bill. So Katie is going to over our next steps completely but it think what we are going to do is (staff) and we're going to do this not just with our projects but with other kind of more NQF, more of a thinking about it is how do you actually try to tap into your expertise, the standing committees.

So, I am hoping that we can at least call you guys together probably more in early fall, maybe. And I'm kind of looking at Katie, she's looking at me. So, we're hoping to put something together some time between fall and winter just to bring you guys back. Again, it's not our expectation at this point that we would have any measures for you guys to discuss. It would just be a general discussion. And part of what we have to do as staff is really get more clarity on what we really want you to do. We have used the term, you guys are overseers of the portfolio (inaudible) measures. And we've laid out some things about what that means. But we really – to be honest with you, we need

to go back and revisit back and try to grow from where we were a year and a half ago and where we see this going. It really is an involving thing. So – but that's not something that will come fast, I don't think.

So, that's for the committee long-term, probably six months, that we'll – maybe try to get you guys back together. But in the short term, Katie would tell you next steps for the project.

Katie Streeter: So, next steps for cycle three, we will finalize your responses to the comments received, and we'll be updating the draft report with those responses. The two measures that were recommended will be made available for NQF member voting beginning next week for our 15-day period. Then, the measures will be presented and your recommendation will be presented to the CSAC in May. So, we will be following up with Bill and Jamie to see if they can hopefully attend for one final time to present the measures and the summary of your discussions.

The measures will follow the rest of the regular process after that for approval in June and then appeals in July. And then, we'll be finalizing the report and by the end of the summer. So we will keep you posted as we progress through each steps. We'll send you an e-mail with updates. And as we move along, please feel free to reach out to us with any questions or comment, we'll still be here.

Karen Johnson: Yes. And just so you know, we do regularly try to get feedback from folks who participated or are currently participating on committees. So, if anything jumps out you and you just want drop us a line, we're always happy to get feedback on anything. And we're always happy to answer questions. So, if there thing that we can help with as you go out and do your thing in your world, we'd be happy to help with that if you need us to.

Katie Streeter: OK, before we end, we'd like to open up the lines and see if any NQF members of members of the public have any comment?

Operator, are the lines open?

Operator: Yes. All lines are open.

Katie Streeter: OK. And if there are no comments, we'd like to thank our developer, Collette, for attending and participating in today's call as well. Your input was really helpful and clarification. And thank you to all of our committee members for taking the time in participating today. We really appropriate your hard effort on this project.

And with that, I think we are ready to end today's call. Hope everyone has a great afternoon.

Karen Johnson: Thanks, everyone. Thanks.

Male: Thank you.

Male: Bye now.

Female: Thank you.

Female: Bye-bye.

Female: Thank you.

Operator: Thank you for participating. You may now disconnect.

END