NATIONAL QUALITY FORUM

Moderator: Measure Developer Maintenance
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OPERATOR: This is Conference #: 1708062.

Operator: Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please standby.

Karen Johnson: Thank you, (Bridgett). And welcome Endocrine Standing Committee members. It's been quite a while since we've convened. So thank you for joining us today. This is an off-cycle meeting.

So, if we'll go to the next slide, please.

We have an interesting afternoon, hopefully, you'll find it interesting. We'll start out with introductions to make sure everybody remembers all your fellow members of the committee. And I'll give you a little bit more information about what we are trying to accomplish with these off-cycle activities. And then we're going to delve right into our programming for today.

So, there's kind of two major portions that we want to do. One is a MAP overview. I'm going to go through that fairly quickly, but it's something – it's one of the – really one of the major functionalities of NQF. And I know we talked about it back in our first meeting but that was a long time ago. And it may be a while since you thought about the MAP. So we wanted to make sure that you understood that in case you have questions. It's pretty interesting process.

We'll then have a little refresher and remind you guys of what we accomplished in three cycles of measure evaluation. And then, the bulk of our afternoon will be talking about NQF's strategic direction and getting some feedback from you guys as committee members.

We have a lot to think about as we try to implement our strategic direction. And we really want to hear from you just your thoughts on some questions that I teed up.

So to get us started, let's go to the next slide. And I'm just going to call out different names. And I'm going to start with Jamie Rosenzweig. Jamie, would you like to just say hello to everybody and welcome folks to our off-cycle activities?

Jamie Rosenzweig: Are you on mute?

Karen Johnson: No, we're not on mute, Jamie. Are you there?

Jamie Rosenzweig: Can you hear me now?

Karen Johnson: Yes, there you go.

Jamie Rosenzweig: Can you hear me?

Karen Johnson: Yes. We can hear you, Jamie.

Jamie Rosenzweig: OK. I got an echo here.

Karen Johnson: (Bridgett), can you help us with that echo on Jamie's line?

Jamie Rosenzweig: No, I think I may have to use …

Operator: And Jamie, you might need to mute your computer speakers.

Jamie Rosenzweig: Yes. Yes. My computer speakers don't seem to be working but …

Can you hear me now?

Karen Johnson: Yes. Much better, Jamie. All right.

Jamie Rosenzweig: Sorry about this. I echo …

Karen Johnson: That's all right. I forgot to remind everybody.

Jamie Rosenzweig: Yes. So I'm Jamie Rosenzweig. I'm a practicing endocrinologist and I'm the chair of the Quality Improvement Committee of the Endocrine Society. And I've been active in a lot of issues related to diabetes, the disease management, diabetes performance measures and other endocrine performance measures. And I'm the – or a co-chair of this committee. I'm happy to welcome everyone.

Karen Johnson: Thank you, Jamie. Appreciate that. I'm just going to call, I'm going to go down our list here. So, when I call your name, if you're attending, let us know that you're there and maybe give just a very brief title, where you work, that sort of thing.

Bob Bailey?

Bob Bailey: Yes, good afternoon. I'm here. And so I work on the Health Economics and Outcomes Research team at Janssen Scientific Affairs and I've had a minor change in role. I'm now working on the Population Health Research team at Janssen. And by way of background, I'm a clinical nephrologist by training.

Karen Johnson: Thanks, Bob. Bill Curry?

Bill Curry: Hi. I'm a family physician at Penn State at Hershey, Pennsylvania. I'm medical director for our Care Management Department and our Accountable Care Organization here at Penn State University.

Karen Johnson: Great. Starlin Haydon-Greatting? Sorry if I got your name wrong.

Starlin Haydon-Greatting: Hi. No, that's fine. Greatting, great. It's probably Greatting because it's German, but in the Midwest, they say Greatting.

I'm a pharmacoepidemiologist, meaning I'm a pharmacist and I have a degree in epidemiology. I work as a program director for a diabetes education program and chronic disease management. I'm also in-charge of population

health. And in a previous life, I was director of Quality Assurance for Medicare for the state of Illinois.

Karen Johnson: Great. Janice Miller?

Janice Miller: Oh, good afternoon, everyone. I'm a nurse practitioner and a certified diabetes educator. I am an assistant professor of nursing at Thomas Jefferson University, College of Nursing in Philadelphia. And I am also a health policy fellow of the American Association of Colleges of Nursing.

Karen Johnson: Thank you. Bill Taylor?

Bill Taylor: Hi, good afternoon. I'm a primary care general internist at Beth Israel Deaconess Medical Center in Boston, and the director of Medical Education at Atrius Health, which is a big group practice. And I run a primary care residency program that's based inpatient in Brigham and Women's Hospital outpatient at Atrius Health and under the leadership of the Department of Population Medicine at Harvard Medical School.

Karen Johnson: Great. Grace Lee?

Grace Lee: Hi, I'm Grace Lee. I'm a practicing endocrinologist out of Seattle at Virginia Mason Medical Center. I mostly practice but I also do a little bit of clinical trials and a research on preventing early progression of diabetic kidney disease and do some type 1 diabetes and type 2 diabetes epidemiologic research.

Karen Johnson: Thank you. Tracey Breen?

Tracey Breen: Hi, this is Tracey. I'm an endocrinologist by training. When we started this project in my last role, I was the director of Diabetes Care for the Northwell Health System. Since then, I've transitioned to a new role. And now I'm chief medical officer at Mount Sinai West which is a 500-bed hospital part of the Mount Sinai Health System. So still interested in diabetes management but wearing a slightly different hat this time around. Thank you.

Karen Johnson: Congratulations on the move. Vicky Ducworth?

Vicky Ducworth: Hi, there. My most recent role was at The Boeing Company. I was – I oversaw our Clinical Programs and Delivery Systems Innovation. Prior to that, I was a program director at South Carolina Medicaid. And prior to that, I was the quality director for a large multi-specialty group.

And so, again, I recently had a role change. I'm unable to announce that today, probably the next week or two. Currently, I am just wrapping up my graduate studies in Systems Engineering.

Karen Johnson: Congratulations.

Vicky Ducworth: Thank you.

Karen Johnson: Jim Dudl?

Jim Dudl: I'm an endocrinologist with Kaiser Permanente. I'm the diabetes lead with Care Management Institute of Kaiser, and interested on and working also in community that are fit with Kaiser.

Karen Johnson: Great. Ingrid Duva?

Ingrid Duva: Hi. I also in the midst of a role change, but I just wrapped up a three-year fellowship in quality improvement with the V.A. System here in Atlanta. And my – the reason I was involved in diabetes is because I have a research background in management of nursing issues and then most recently, was conducting a study with primary care in V.A. and the role of the R.N. in the primary care centers. I'm also affiliated with the Emory University here in Atlanta.

Karen Johnson: Great, thank you. Ann Kearns?

Ann Kearns: Yes, I'm an endocrinologist at the Mayo Clinic in Rochester. And I'm the chair of Quality and Endocrinology here.

Karen Johnson: Great. Anne Leddy?

Anne, if you're there, you're on mute.

Anne Leddy: Thank you for that little sort of guidance there.

Well, I'm Anne Leddy and I am retired from 40 plus years practicing clinical endocrinology. And now I'm a volunteer at our county free clinic, so to speak. And I actually see several patients who formerly paid to see me, who've come onto hard times. A lot of the patients have diabetes, although it's a pretty broad general endocrine clinic.

I am on this committee of the NQF as a representative of the American Association of Clinical Endocrinologist. I'm finishing my last year of the second term on the National Board of Directors and I'm a member of the task force on the MACRA, and how it affects our members. And so I'm involved in developing an alternative practice model and also working with MIPS.

Karen Johnson: Great. And Anna McCollister-Slipp?

Anna, if you were there, you are also on mute.

OK. It looks like Anna may not have been able to join us today.

So thank you guys for those great introductions. I forget how wonderfully accomplished all of our committee members are sometimes until I hear you go through all your credentials. It's great.

You'll probably notice that there are a few names that you probably remember from earlier encounters that are not on our list. A few people did move around and because of those move arounds, were not able to continue on with the work of our committee.

So for now, we will just not try to replace those members. We will probably have to add members to make sure we have all of the correct representation the next time around when we need to do some endorsement activities. In particular, I did want to talk about Bill Golden who, along with Jamie, was one of the co-chairs of the committee.

Bill actually transitioned to another role for NQF. He is now on our Appeals Board. So, without going into too much detail, we have changed a few of our

processes here since the last time we worked together. And one of those things is the creation of an Appeals Board. And unfortunately, it was one of those things that Bill could not do both. He couldn't be on the Appeals Board and be on a standing committee.

So, for some reason, he chose the Appeals Board instead of us. But, anyway, we hate to see him go. But wish him well on thinking about those appeals.

So let's go to the next slide. I wanted to through very quickly what we're doing today. What is this call? We're not going to be looking at measures for the next several months at least. So, what we're doing we are calling off-cycle activities.

And basically the goals are – of these activities or these calls or webinars is to maintain engagement of our committee members. It has been, I think, over a year or probably close to a year and a half since we've gotten together. That's a long time. So we wanted to make sure that we stay engaged with you.

And also give a little opportunity to do some different things outside the endorsement process. So we are planning to be doing a webinar on a quarterly basis. So, there'll be one sometime probably in March and then another one in early summer and then probably in the early fall.

And we have a lot of possible topics. And Jamie and I have been talking about what those topics might be. And these are some of the ones that we've come up with so far, prioritizing gaps in measurement, MACRA, because I know that's in a lot of people's mind, potential updates in guidelines. You know, what's coming down the pipe that you guys might know about. T1D exchange, that's type 1 diabetes exchange, something that Jamie felt might be an interesting topic of discussion.

And then there's always stuff that we can tell you about NQF. We could have a refresher course in terms of our criteria or even take a deeper dive, if you wanted to, into things like reliability or validity. Maybe only a few people would like that, and that's fine. These are just topics that we had thought about doing.

So, what I'd like for you guys to do is think a little bit about what you think might be an interesting topic that would work to our webinar. And let Jamie and I know and, you know, with your topics if you have any and then probably these, we'll choose a few to do throughout the next year.

I can almost guarantee you that one of them will be the prioritizing gaps in measurement. That's something that we do try to talk about in our endorsement meetings, but sometimes we're hitting the clock and don't get to have as robust conversation about that as we would like to.

Helen Burstin: And Karen, if I could just add one thing. This is Helen Burstin, just welcome to everybody.

Karen Johnson: Thank you, Helen.

Helen Burstin: I just want to make one quick comment. And really the idea of moving to standing committees, from our perspective, was to have a group of folks who we know, who we work with, who understand our process, but who also can be there as issues come up in this area.

We don't really want to ever have to convene, you know, yet another group to offer input on anywhere along all of NQF work where an endocrine issue might come forward. We would like to be able to come back to this group and get your input. So, it really is a way for us to kind of bake your expertise into what we already have.

Karen Johnson: And thank you for that, and apologies for me not introducing Helen. We're very fortunate to have Helen's time and I think, again, the last part of this call is really going to be interesting as Helen tells you about our strategic direction and talks you through some questions.

Let's go ahead and talk about the MAP. What is the MAP? You know, it's the Measure Applications Partnership. It is a multi-stakeholder partnership that is convened by NQF. And what the partnership does or what this – the MAP does is provide input to HHS on measures that may or that really that are being considered for use in federal programs, specifically CMS programs.

This was authorized in 2010. And part of the – just like anything really that NQF does, we want to have a multi-stakeholder representation. So, it's public and private. And really, one of the important things that the MAP does is allow a coordinated look across federal programs. So you'll see that as we go through the slide deck.

So let's go to the next slide and the next one. So, really, the MAP came along and – and let me process this. Why do I want to tell you about the MAP? Well, number one, many of you probably know about different CMS programs that are being used, public reporting or pay-for-reporting or even pay-for-performance programs. And you might be curious how the process works. And actually NQF does have a role in that process.

And we are coming on what we call here at NQF, MAP season. Actually, we've already started MAP season and we're in it now. So, I thought it would be interesting to you, don't want to spend a lot of time on it.

But, the Measure Applications Partnership or the MAP actually is part of statute. It's part of the ACA and it requires HHS to contract with that they call a consensus-based entity which right now is NQF, again, to convene multi-stakeholder groups to provide input on the selection of quality measures for public reporting, payment, and other programs.

So let's go to the next slide.

So, the role of the MAP really helps inform the selection of performance measures. And providing input to HHS on pre-rulemaking, and I'll describe that a little bit more later. The MAP also identifies gaps in measurement, and kind of the whole measurement enterprise, as well as gaps in – and probably more specifically gaps in particular programs.

And then another very important piece is that it encourages alignment across public and private programs. So, that was one of the things that the MAP has actually had sort of success in kind of corralling, if you will, so many measures being used that are similar but different across – lots of different programs.

So, to date, MAP has provided input on more than 200 measures for nearly 20 federal programs.

So, let's go to the next slide.

We use the word rulemaking. What is rulemaking? Well, that's the process that government agencies like CMS use to create regulations. So, if you remember, you know, your (civics) class or where we learned this back in high school or college, Congress passes the laws or statutes. They're very broad. And then, often, it takes bodies like HHS or others to actually interpret and operationalize those broad laws. So, Congress sets the policy. The public is informed of and can comment on proposed rules.

Usually – so what happens is HHS and other agencies like them will propose rules and publish those in the Federal Register and then the public can comment on those, and then finally, the agency will come back and finalize rules. So you'll see – you know, you will see, you know, the draft rule and then the final rule will come out a few months later. These final rules were kind of interesting to read because you'll see the comments and the responses that the agencies make to the comment.

So the MAP actually – we could have actually drawn a little arrow here to tell you that the MAP comes in between those first and second arrows. So, what we call internally here, we call it the pre-rulemaking process. So it happens before those drafts rules are written.

Let's go to the next slide.

The value of pre-rulemaking is that it facilitates multi-stakeholder dialogue. And one of the nice things, and you'll see this going on at – you know, these groups sit around the table, the same table pretty much that you guys as a Standing Committee (sitting) around. But we have representatives from HHS in the room. So they hear the different perspectives. They're there listening and taking notes, that sort of thing. So they hear all of the input.

We – again, it allows for a consensus-building process across multiple stakeholders just like our endorsement processes, it's open and transparent.

The public can and does attend. We record the calls. We make those recordings and transcripts available on our public website.

We hope that the regulations are closer to the mark because they've been vetted by stakeholders around the table. And also, hopefully, reduces the efforts of individual stakeholder groups to submit official comments because they have been able to comment as part of the MAP process.

Let's go to the next slide and then actually the next one.

So, how do we structure the MAP? It's pretty complicated in a way. It actually has an overarching body what we call the Coordinating Committee and then four standing workgroups. And you can see there, there's a hospital workgroup, a clinician workgroup, and post-acute care long-term care workgroup or PAC/LTC as we like to call it. And then there's also the dual eligible workgroup.

And then you see that triangle on the shaded underneath there. We also have a couple of time-limited task forces that also provide more specific input on certain issues.

So, the way it works is the individual workgroups actually look at and offer input on specific measures, and that input goes to the Coordinating Committee who then finalizes input that goes to CMS.

So, next slide.

The MAP is actually structured quite a bit differently than our endorsement committees. In the MAP, for all the different workgroups as well as the coordinating committee and the task force groups that we have, there's three different kinds of numbers. First, there is organizational representatives, and that's most to the MAP members and each of the workgroups. And they – the difference there is that the organizational members really are – they're chosen by the organization to be seated on the MAP. And that person represents their entire constituency.

So, unlike you guys, even though you may have been recommended to our Endocrine Standing Committee by a particular group, you're on our standing committee because of your personal expertise and experience. So you're bringing in your own personal opinions and knowledge to the group. You don't necessarily have to be speaking for your, you know, nominating agency.

But, on the MAP, the organizational members are representing their organization. But we also have subject matter experts. So, they are invited to the MAP. They have a nominations process that's similar but different to what the standing committees for endorsement have, but the subject matter experts actually represent themselves and they're there, again, for their subject matter expertise.

And then finally, we have federal liaisons. So, these folks are from different federal agencies. And they listen and contribute to all of the discussions but they do not vote. So, that's how the membership works on the MAP.

So let's – the Coordinating Committee Charge is to advise HHS on the coordination of performance measurement strategies. They provide the strategic direction for the MAP. And as part of that, they also provide direction to the MAP workgroups, because we want the workgroups, even though they have different areas that they're thinking about and different programs, we want them to have a consistent approach in their thinking. So, that comes from the Coordinating Committee.

And the next slides, I'm going to flag through. I don't really expect you necessarily to read them on the screen. You can look at them at your leisure later if you would like to. But I did just want to show you the different members of the various committees. You can see here that we have co-chairs of each committee. We have a lot, and again, the majority are organizational members and then you can see the subject matter experts. And then for the Coordinating Committee, you can see our federal liaisons. So we have folks from AHRQ, CDC, CMS and ONC on our panel for the Coordinating Committee.

And there'll be similar slides for the various workgroups as well. But the Hospital Workgroup – actually if you go back one, please. The Hospital Workgroup – I wanted to show you this slide because as its name implies, the Hospital Workgroup provides input on measures to be implemented that are in programs that are directed towards hospitals.

So, the IQR, Hospital Meaningful Use Program, the VBP Program, feels like alphabet soup. I'm not going to read all of these off, but I imagine that most of you are familiar or have heard of at least one or two of these programs and possibly all of them.

So, the next slide just shows you the workgroup members of the Hospital Workgroup. Again, same kind of structure, mostly organizational subject matter experts and then the federal liaisons.

The Clinician Workgroup, again, works on measures that are going to be focused on clinicians. So, right now, starting with this year, they will be looking at the MIPS Program of the Quality Payment Program. So, you know, the QPP, that's actually kind of new alphabet soup for us but that came out of the MACRA legislation. But the Clinician Workgroup also provides feedback and input for the MSSP Program that is used by Accountable Care Organization.

Again, this slide just shows you who the clinician workgroups are.

The PAC/LTC Workgroup, they have a little bit of a smaller list in terms of the number of programs that they have to provide input on. So it's the ones you expect, nursing homes, home health or long-term care hospitals and hospital program.

This year, we are implementing a pilot test of the feedback loop mechanism of process with the PAC/LTC Workgroup. So basically, one of the things and we might get into this a little bit later, I'm not quite sure if we will or not. But, you know, endorsing measures or providing feedback on selection measures, sometimes it feels like there's a bit of a hole because we might not really know what's going on with these measures out in the field or at least we might not, you know, have a good handle on some of that as we would like to.

So NQF is trying to figure out, quite frankly, how and do better in getting feedback on measures and implementation. So this is going to be one of our ways to trying to get some additional feedback. We'll see how that goes.

The next slide really just shows you the workgroup members. And let's go to the next slide.

There's also, as I said, besides the four workgroups and the Coordinating Committee, we may have to provide guidance on programs that aren't actually subject to rulemaking. So right now, we're doing that with the duals that actually has its own workgroup, but also task forces, the Medicaid Adult and Child Core Set Work. And in the past, we've done some work on the Health Insurance Exchange Program, et cetera.

And this slide just tells you a little bit about the role of the Dual Eligible Beneficiaries Workgroup. We usually just call it the Duals Workgroup because, you know, it's easier to say.

But, you know, dually eligible beneficiaries, you know, they're included, of course, if patients across, you know, hospitals and clinician programs and long-term programs. So, the Duals Workgroup really doesn't focus necessarily on specific programs, but they provide basically the perspective of the duals population to the other workgroups into the Coordinating Committee.

So they actually – the next slide gives you a little bit more detail about what the Duals Workgroup does. But, one of the things that they do is maintain a family of measures that are relevant for the dual eligibles to promote uptake and alignment of those measures across the various programs.

And this next slide, again, shows you who those members are.

And then, finally, I want to just let you know that we also, as part of our task forces, provide input on the Medicaid Child and Adult Core Sets of measures.

On the Medicaid side, their quality programs are in a different place than the Medicare side is on. So basically, the way it works right now is states are being asked to voluntarily report on a selected set of measures core set and there's a core set for adults and there's a core set for children.

So, these task forces meet and discuss things that are going on, you know. A lot of the discussion is about some of the implementation issues that folks are having, but they also think about gap areas and recommend potential measures for additions or deletions to the core set. So, pretty interesting work there.

Again, it does feel very different because it's voluntary. Measures are rolled up state, so it's interesting.

The next slide really just shows you and the next one shows you the numbers of the adult and child core sets.

And what you'll probably notice there is for the most part or at least some of the folks on the task forces are pulled from some of the other workgroups and the Coordinating Committee.

So let's go very quickly, and I know I'm going fast, but I wanted, again, mainly just to make you aware of this activity, but we could also open for questions a little bit later.

As I said, we're in MAP season now. What does that mean? Well, it means that we've already started.

So in September 27th, the Coordinating Committee met. They were here in D.C. for a one day in-person meeting. And they talked about some key issues. One of which was to talk about how staff will be doing these things called preliminary analysis. You guys got a flavor of a preliminary analysis that staff does back when you were doing some endorsement work for the endocrine measures. But, we have actually expanded and hopefully refine some of that process now on the endorsement side.

On the MAP side, they have something similar. It's obviously a very different analysis, but it's basically the idea that staff would do a look and give maybe a

preliminary weighing and that just kind of gets the committee off to a good way to begin a discussion.

The workgroups in the meantime will be familiarizing themselves with the various programs because they'll be providing feedback on measures that might be added to the program, so they need to understand what they are already.

Then the workgroups will evaluate measures under consideration. If you're kind of in the no, you may hear the term MUC list, M-U-C, MUC list turnaround. That stands for measures under consideration, so that's a list that comes to NQF. I believe it's on the 1st of December or maybe a day or two before. But, basically, those are the measures that the MAP will be looking at. So, measures on the MUC list.

And then the Coordinating Committee will actually examine issues and make their recommendations late January.

So, on the 27th, the committee actually talked about their process including their decision categories, and I won't go into details on that. But, they really talked about, you know, what kind of feedback is really helpful to HHS and part of that discussion was, you know, unlike endorsement which is the yes, no, they had some different categories that they can actually put forward in terms of their feedback.

So this timeline shows you – and you may have to put your glasses on to see that really well. But basically, MAP season is a fairly short but intense season here at NQF and for all of the folks here on the committees. Basically, I think started in September with the kick-off meeting and they will – for the most part in – by the end of January.

So, in between that time, the workgroups will have in-person meetings and there'll be two comment periods and a coordinating committee meeting, and then finally, NQF will produce a report. And that report – report might be kind of a bit of a wrong word, but basically, NQF will make the recommendations from all of the workgroups and the committee's public basically and final.

So, the upcoming activities, there'll be some web meetings. And as I said, the individual workgroups will have their in-person meetings, mostly in the month of December.

So, with that, I know I went through that very fast and …

Helen Burstin: Karen …

Karen Johnson: … but do you have questions, yes. Helen?

Helen Burstin: Yes, it's Helen. I just want to put some of this – again, it feels a little bit out of context so I think for many people on those call, but I want to, again, tie it back to your role on the Endocrine Steering Committee – Standing Committee.

So prior to this, as we look through these measures under consideration that Karen mentioned that are bringing – brought forward for consideration is different federal programs, you know, that there could be an opportunity for us to weave in some input from the Endocrine Committee and anything that may be endocrine related.

One of the other things that the committees will be doing – the MAP workgroups will be doing this year that's different is also looking at the existing measures that are already in that host of federal programs, and indicate where there may be measures that have outlived their usefulness. And I recall that really rich interesting discussion the Endocrine Standing Committee had, for example, about the question of whether it makes sense to maintain the monitoring of hemoglobin A1c if you already have an outcome measure that looks like hemoglobin A1c control.

So those kinds of issues may come forward, and again, this is where I think it's an opportunity for us to gather your input since at the – you know, at the endorsement tables, we really do ask you to kind of focus in on the issue of the quality of the measures before you, and not consider the payment context. And it's really in the MAP context that those issues become front and center

and where I think we want to increasingly pull in your technical knowledge as needed as some of these measures come forward.

So that's really just the context for why we thought it was helpful for you to hear about the MAP process as it unfolds and also since the MAP also does help with some of the gap analysis and some of the specific thinking around programs. You know, even some of the measures you've looked at in the last couple of years, you know, might there be measures you think in the future we should try to encourage the developers to push towards the list of measures that would be under consideration, so really just to give you that context.

Thanks, Karen.

Karen Johnson: Thanks, Helen. That helps and I should have set that stage earlier. My only excuse, which isn't a very good one, is that I actually don't staff the MAP, so I'm learning about this as we go, I think.

But do you guys have any questions about the MAP work and how it works?

Jamie Rosenzweig: This is Jamie. Yes, I have a couple of questions. The MAP – this is function mainly for Medicaid or there are other programs that it also works for.

Helen Burstin: You know, Jamie, it's Helen again. It functions for almost all of the Medicare-related programs, the almost 30 programs across all of Medicare as well as Medicaid. So it's actually got a very broad purview.

Jamie Rosenzweig: OK. I would see that our committee could provide valuable information to at least some of these workgroups. If there's not a lot of representation of endocrine-related organizations on the overall workgroups.

Helen Burstin: Yes, I agree. Definitely.

Karen Johnson: Yes. And I have a diagram that I'll show you in a few minutes that will give you a little bit more flavor about how you actually do provide input.

Any other questions about the process itself?

All of those meetings that I flashed up very quickly in front of you, remember those are open to the public. So, if you're interested in dialing in or coming to our offices and sitting in, feel free. You might enjoy it. The conversations, I think, are very different in the MAP. It's how we've said that the purpose is very different. You know, we don't – you know, sometimes they do delve into kind of adjudicating measures but really that's the purview of the endorsement committees. The MAP is thinking about something else. So, again, the – some of the conversations are different but still quite interesting.

OK. If you have further questions, be sure to just, you know, drop me an e-mail and if I don't know the answer, I'll find somebody here that does. But let's go on. I wanted to give you a very quick refresher about NQF and our evaluation criteria and about your work as the Endocrine Standing Committee.

I'm doing this mainly because it has been a year and a half or so since we've gotten together, but just wanted to put these criteria up in front of you. Again, these are pretty much the same criteria as you used the last time you were with us. We have added one extra sub-criterion under usability and use that has to do with vetting in the measures by folks that are being measured or by others. So, it's a way to hopefully drive the measurement enterprise a little bit. We'll see how that works, so that is new.

But, again, just to remind you, there are five major criteria, importance to measure and report, scientific acceptability, feasibility, usability and use. And then if a measure makes it through all of those, we would consider issues around related or competing measures.

We have – we've stuck with the idea of the must-pass, so evidence gap or opportunity for improvement, reliability and validity, all of those things are must-pass criteria. But right now, feasibility and usability and use are not, but they are really since we talked the last time, we have actually changed our process a little bit in terms of maintenance measures.

When you guys were with us before, we treated maintenance measures exactly the same way as we treated brand new measures and maintenance measures that means previously endorsed measures. So measures that we have

endorsed ones before and they're coming back to us after three or four years for another look.

And basically, the change and process there has to do with the idea that if the evidence underlying the measure has a change and/or if there's been no additional testing for reliability or validity, then there really isn't much need for the committee to spend time discussion – re-discussing those issues. And instead, we're asking committees for those previously endorsed measures.

We're asking committees to think and spend more time thinking about opportunity for improvement about feasibility and then about actual use of measures in terms of, are they being used? Are they driving improvement? Have there been unintended consequences? So it's a – it's not a change in the criteria, but it's a change in the focus, again, for previously endorsed measures. So, you'll be seeing that when you guys come back at whatever time and actually go through the endorsement process with us again.

Now, this diagram is meant to show that we are integrating or have integrated really the endorsement process with the MAP process. And basically, right now, it's a matter of information, although as Helen said, it may be a little bit more active perhaps in the future. But basically, when you guys as a standing committee talk about measures and make your endorsement recommendations, we staff write all of that stuff up and we put it out in these reports.

Well, what we have done in the last couple of years is we provided that in-depth summary of your discussions to the actual MAP Committee. So now that that committee sees not quite the minutes of your discussion, but it's the salient points and they see the – how things were rated in terms of your votes, all of that goes to the MAP.

In turn, when the MAP sees a measure that may be coming to a standing committee, we let the Standing Committee know, number one, that the MAP discussed it and then number two what the MAP said about it, you know, whether they were in favor, not in favor, particular issues, et cetera. So, a bit of a feedback loop in both directions.

And then finally, there's this other piece, sometimes what we're seeing were more often in the MAP process is measures that are coming to the MAP that have not yet been through the endorsement process. And when those are actually supported by the MAP, we reach out to those developers and try to make sure that they know when they can bring those measures to us for potential endorsement. So there's a little bit of kind of closing loops there to the extent that we can.

So, let's go to the next slide.

Just a reminder about our endocrine portfolio, so the word portfolio should have been on there, not quite sure how I managed to forget the word portfolio. But just a reminder, our measures right now are about diabetes and osteoporosis. Unfortunately, no others.

We have now 44 measures in the portfolio, 30 of those are process measures, 12 are outcome measures and we have one composite measure in that portfolio. One thing that is a little different from the last time that you guys met, is that since that time, there are three additional measures to the portfolio that are actually eMeasures that are being – I think they are being used in programs now, in federal programs.

But, anyway, you may recall that the hypo and hyperglycemia measures that you guys looked at were really one of the first, actually they were the first, I think, de novo eMeasures that came through our process, you guys, that could be the ones to look at that measure.

So we have had additional eMeasures come through. Again, the new ones aren't de novo, they were, you know, initially specified as probably paper-based measures, but they have now been turned into eMeasures. So, a little bit of growth in our portfolio.

In terms of gaps, and I didn't make a slide for gaps. But, at our in-person meetings, we try to talk about gaps and some of the ones that you guys mentioned specifically were the need for measures around thyroid conditions, measures that's overused, especially for thyroid conditions. Pre-diabetes

measures, measures that look at time and range, so it's kind of a different way of thinking about blood glucose control.

Another topic area that came up a lot was hypoglycemia, particularly either in the elderly or in outpatient settings, and we actually don't have measures for either of those two or one hypoglycemia measure with an inpatient measure only.

Other gaps that were mentioned were about use of testosterone, quality of life measures, and primary prevention of type 2 diabetes measures. So, again, I think one of our off-cycle calls, I would like to devote to a more thorough discussion of measurement gaps.

Go to the next slide.

And before I delve into some of these issues, I will also remind you that your work previously was part of a pilot. So, you may recall that we had three cycles of endorsement. We call them cycles, and each cycle was about six months apart. So you look at in-person here in our offices. I think you looked at 17 measures across a couple of days.

And then a few months later, you looked at a few more measures via a webinar and then a few months later, another set of measures and that was a pilot that we used to try to see how it would work if we had more frequent measure opportunities.

The way it's worked for us for the most part in the last several years has been having a project and – for example, an endocrine project once every three to four years. So, obviously, if new measures come along and, you know, they did happen to miss our project, they might have to wait for a long time for another one to roll around.

So we actually learned a lot from that pilot. And I won't go into details now, but we are hopefully going to be able to put some of those lessons learned into play for ongoing work. So we'll see how that works out.

And I wanted to spend a little bit more time on this slide, because I think this will kind of tweak your memory a little bit and I think it'll come up and help you in your discussion with Helen.

So, some of the issues that came up when you were endorsing all those measures, there was quite a bit of discussion about the threshold values that were used to measure it. So, it was a very interesting discussion and one that I think you guys came to really get consensus on those measures.

But you also had some problems, I think, or some difficulties in removing endorsement of measures. Because there was a concern from you guys, I think, that if you remove endorsement, perhaps if a measure was topped out, you know, kind of added peak that it might signal to the field that that topic area or that care process isn't important.

So, that was definitely a part of our conversation at the time, and I will tell you that since you guys did your endorsement work, we have actually strengthened our policy about reserve status. So now, we're, I think, more consistent across committees on – when things are put into what we call reserve status, if there's still a good measure, they're just topped out, there's really no more room for improvement. So, I think that was something that your work helped us see that we needed to have a little bit stronger policy statements on that.

When you were in – evaluating measures, you actually looked at several different competing measures. And in some cases, we did ask you, actually, I think in three different cases for the foot care measures for the testing versus good and poor control measures, and then for individual versus a component and a composite measure all through those scenarios.

We actually asked you if you could choose a superior measure, and you were not able to choose a superior measure. So we – you were able to provide justification for why we need multiple measures.

There were also several related measures that we asked you to consider, particularly around the osteoporosis measures. And you guys did provide

quite a bit of concrete feedback to developers on how they might harmonize their measures.

And then finally, another issue that cropped up in several of the measures, particularly the diabetes measures, was that there seemed to be relatively little improvement in performance over in recent years.

So – and I don't remember exactly what the performance rate were for the various measures, but you may recall that improvement is actually (inaudible) sub-criteria under usability and use. So, regardless of seeing little improvement for the most part, I think those measures were – those maintenance measures were re-endorsed.

So, let me stop there and see if you have any questions for me about anything that I have presented thus far. I know it was a very quick refresher.

Does this bring back the memories to you on your time with us and the work that you did?

OK. So, I'm going to assume that nobody has any questions.

And now, really, the fun part of our program starts. And I'm going to hand off to Helen to talk through us about NQF strategic direction and then we'll go from there.

Helen Burstin: Great. Thanks, Karen. So, I wanted to give you a little bit of an overview of where NQF is going and really get your input and think about how the Endocrine Standing Committee can help us get there.

So next slide, please.

So this is just a visual, and I'll spend a fair amount of time on this, just easier – you've seen a lot of words in the last hour. So, seeing very few words to follow.

So really, as we thought about what NQF's role could be going forward, we really wanted to ensure that we have the ability to drive measurement that

matters, which is the center of this, to improve quality, safety and affordability.

And there was a sense we could do that through helping to lead, to prioritize and obviously a lot of our work is with other organizations through collaboration, and doing that through our work on advancing measurement science as well as expanding NQF and NQF's member influence.

And in terms of the environment – the measurement science work, which is actually a growing part of our portfolio that perhaps we could talk about with you on subsequent calls. This is really about – thinking about the crosscutting issues that cut across measures, so that it's not really a unique issue to a particular measure to look at issues of attribution, or risk adjustment or the degree of variation between measures, but really think about it as an opportunity to set some guidance that work across all of our committees.

So we have a report out, for example, right now on attributions looking at a set of principles as well as recommendations for how care can be attributed back to individual providers, teams, et cetera, as well as a set of recommendations for how attribution model should work going forward, and even develop an attribution model selection guide to help move the field forward in that way.

So it's that kind of work we think is going to be really instrumental to thinking about how we get to the next generation of better measures, how do we handle some of the issues of measures that use more and more for payment and public reporting than ever before.

So part of this is really is the idea that we really need a good feedback and cycle in the measure development implementation and use space, and a big part of that is at least initially thinking about how do we accelerate the development of needed measures.

And as Karen mentioned, you've done a fair amount of work over the last several years coming up with a list of what you think the most important gaps are. For example, I remember the discussion around a measure of

hypoglycemia in the outpatient space, even though we have one of the inpatient space.

And you know, NQF's role of being on the receiving end of measures has not felt satisfying enough for many of us, and we're really are trying to think about how we could help accelerate the development of needed measures. And part of the way we'll do that is by working through our process of setting criteria that can be used to prioritize both measures and gaps. And those criteria will be coming forward to you likely in the next time you meet to help us say, even among the measures you've endorsed, which ones are most important and we'd be happy to share those criteria with you as they're finalized in the next couple of months.

As well as really having an opportunity to think about what are the most important gaps and how can we help facilitate getting those measures filled. So we've developed a measure incubator that allows us an opportunity to think about how we can build off of the work we already do, not to develop measure since that was not the – an appropriate role for NQF. But instead, how can we help facilitate those who have interest in measures, ideas for measures, perhaps measures some of you are using at your local level that are really great but have never really hit the national stage bring together those with ideas, those with data, since you think that's a pretty important limiting step, those with funding and finally those with the expertise in measure development and see if we can really create measures at a much more agile way, faster, hopefully cheaper in the long-term and, you know, hopefully meeting the target better from the get go.

So we're now in the process since it's been kicked off, we've probably incubated about 15 measures or so at various stages of development. So I think there's a good opportunity for us to collectively work with your committee to think about where there might be opportunities, where measures are really needed in the endocrine space and when you go back to that list of gaps, you've already removed – you put forward in the past and think about how we might be able to facilitate some partnerships to get some measures developed where they're needed.

A next important piece of this is we've already heard a lot today about measure selection for specific federal programs through MAP. Certainly, you guys have been very engaged in the endorsement process, but we specifically added the word reduce as part of our strategic planning going forward. And it would be the idea that if we want to be able to move toward some of the more advanced measures we think might be more meaningful to clinicians, providers, plans, patients alike, we have to make room for them by removing measures we don't think are adding value anymore.

So, Karen, for example, just talked with you about, you know, how we might go further in terms of removing measures that are no longer adding value. We want to think about how to prioritize measures that come out of your committee as well as high level that I'll show you in a moment, overarching measures get used preferentially.

And then finally and in some ways probably, I think the biggest gap from my personal perspective is that we know precious little about what happens to measures out there once they get released, endorsed, implemented, put into programs. How much do we know about which measures work to drive improvement, which ones are used in a way that is really just because you have to, their kind of a checkbox for a federal program but they don't really drive improvement.

And then finally, and perhaps most importantly, where are the examples of where feedback on what doesn't work is really important and I was just recalling the conversation you had about the appeal of the glycemic control measures from the V.A. and the concerns about where there are potential unintended consequences.

So I think we want to think about working with you and our committees and NQF members in general how can we create more of a push for the feedback from the field that can help us understand which measures are really driving improvement, which was our – where the benefits are really being outweighed by the burden and which ones are potentially causing harm that we need to move out as fast as possible.

So, long-winded description, but essentially, this is our vision of where we'd like to go moving forward. I think there are some different directions for us, but continuing to maintain our core work certainly around measure selection and endorsement.

Next slide, please.

So this gives you a sense of this prioritization work we're doing. We now have a set of draft criteria that we're going to the CSAC next week for their initial thoughts. And the idea would be, we want to prioritize measures at three different levels.

The first is we want to come up with a set of national outcomes, some of which may already be reflected in some other national initiatives like the IOM Vital Signs report that would really be at the highest levels, how we would move the health care system forward.

We then want to identify measures that are really the driver measures of their accountability measures. You know, for example, if you have total harm as a national outcome at the top of that pyramid, which measures would drive towards reduction and total harm.

And then finally, the prioritized measure at the bottom of the pyramid there really is where you'll come in, which is that use in the criteria we'll set forward and we also have a standardized construct now for measure gap, work with you to help prioritize which are the most important measures of the endocrine portfolio, but also what are the most important gaps that should be filled as part of the portfolio.

So, we hope this will give you more of an opportunity to feel like it's not just what's in front of you, which I recognized at times is not very satisfying, it's certainly not very satisfying to us. But to try to push harder on identifying where we might be able to bring in the measures that are needed or remove the measures that are no longer needed, but also really importantly think with you and I know Karen's got a set of questions on the next two slides. How can you help us think through best methods and approaches for encouraging that feedback that we think is so critical?

So with that, Karen, I think you're moving onto the next slides that really get at discussion.

Karen Johnson: Right, and …

Helen Burstin: I'll stop there and see if there are any …

Karen Johnson: Yes.

Helen Burstin: … questions laid out.

Karen Johnson: We'll see if there's any questions first and then we'll delve into our discussion questions.

Anybody have questions for Helen?

OK. You may as you kind of start assimilating what she said. These questions, we don't have to go through each one of them one by one. They were just some ideas that I had to kick off discussion. And to be honest with you, it – you know, in that diagram that Helen first talked about, the word reduce is perhaps a little surprising to some. So most of my discussion questions have to do with the reduce question or the reduce piece, particularly in light of, you know, your endorsement discussions and recommendations the last time around. But we could certainly talk about feedback. We can talk about prioritization as well.

Although again, you know, the gaps and prioritization, I think, is going to be its very own webinar sometime next year, so we may not want to get too far down that road. But let's just start with these and it's OK if we go down tangents, but I wanted to hear your thoughts.

We hear this a lot. We have too many measures. What are your thoughts on that? And this becomes a – you guys kick in and just start talking.

Jamie Rosenzweig: So I could just start, I think it's quite – I think to a certain extent, we probably have more measures that are needed, but to de-endorse the measure would take, I think, a fairly very rigorous analysis that would be as an

important as endorsing the measure and it could provide a lot of conflicts in the process.

So, you would need to – we would need a whole recommended process for how we might de-endorse measures and we would have to – it would have to be very similar for all disciplines, not just endocrinology but for other …

(Crosstalk)

Helen Burstin: Right. And this is Helen again, Jamie. That's a great point and the expectation would be that we will give you that guidance that we'll work across all of our committees and for measures removed from endorsement.

Some of it is perhaps just moving more and more measures to the inactive status if they are topped out. But, you know, one of the – you know, some of these cornerstone issues like, do you need the process measure if you have the outcome measure are things we could – we very much like to explore with you.

Bob Bailey: And this is Bob. A question along those lines, so is there any evidence as to what happens if the measure is either retired or de-endorsed to overall care?

Helen Burstin: Yes, it's a great question, Bob. It's one people have really struggled, but this is Helen again. The evidence – and again, there have not been very many published papers on this. Would suggest that if something is really baked into processes, which is somewhat subjective, then there doesn't seem to be any decrease in performance when the measure is pulled out.

That being said, there are very few studies, and I think this is where we'll need your expertise where you sit on the ground to really give us that perspective. Of course, this would go through public comment like anything else, but I think – you know, and perhaps not as much of an issue on the endocrine portfolio where you don't have too, too related and competing measures.

But in some areas, like cardiovascular care, you know, we want to at least be able to remove some of the low-hanging fruit where it's really kind of look-alike measures that are not adding a lot of value. I think in the endocrine

portfolio, it's probably more so questions of, you know, how long do we maintain more process-oriented measures when the emphasis is increasingly looking towards outcomes.

(Crosstalk)

James Rosenzweig: One way – go ahead.

Starlin Haydon-Greatting: Sorry. I would – this is Starlin. I was just going to ask just like we try to do post-marketing surveillance on medication outcomes, is there a system to do some post-implementation surveillance on – you know, because I think the reason why we were reluctant to pull measures when we met, it was the fact that we didn't want to leave a void because, you know, it takes seven years for health care to make a good process habit. And so – yes, so, anyways, is there a – is there something that we could start doing …

Helen Burstin: Right.

Starlin Haydon-Greatting: … asking for evidence?

Helen Burstin: Yes, so that's part of what we're doing as part of this broader strategic plan. We're just piloting it this year but we will be making it much easier for anyone at anytime to provide feedback on any measure in an easier way that we'll be collecting that information as it comes forward.

But part of it is, and this is – and we'd love your input, we have to figure out what the push strategy is. Why would somebody want to come forward and give that feedback and, you know, would people feel more motivated to give that if they felt it might be a way to remove measures, I think, aren't being very useful, or really ensure that measures stay evidence based as the science evolve.

Starlin Haydon-Greatting: And to go along with that, this is Starlin again, because we're trying to take care of patients as a center when you have comorbidities like it's – our endocrine and cardiovascular. And so it almost seems like we should have (inaudible) the groups crossing over in a webinar to have that discussion, so that the cardiovascular group and the endocrine group and, you know, does

that make sense, like – so that we're looking at – OK, we're looking at the whole patient and all these things come up of it and so how does this set of measures affect the – taking care of the whole patient.

Helen Burstin: It's a great point, we'd welcome results on that. Again, we've got – we have to have some mechanism of looking, you know, within these specific groups. But you're right, we need a better approach for how to handle how they come together. That's something that Consensus Standards Approval Committee does for us but, you know, your help in thinking through more of that sort of whole patient perspective and measurements particularly important. I mean, as an internist myself, I so rarely see anybody – general internist, I so rarely see anybody who has only diabetes without a whole host of other conditions.

James Rosenzweig: This is Jamie. Oh, I'm sorry, I didn't mean to interrupt. But …

Female: Yes.

James Rosenzweig: … one way of dealing with this issue would be to have the NQF endorse a measure for a set period of time, like 10 years or something like that and requires the – you know, come up for a renewal or the re-approval on a certain period of time.

Helen Burstin: Right. And all of our measures do that every three years, I think the challenge is, without the information from the field, how can you know necessarily what to do with it, short of just knowing the current rate of performance versus the rate of performance three years ago. But that may not give you the information about how it plays out in different patient populations, who may be at risk of disparities. It may not play out about how it might be different for safety net providers versus others. So, we really feel like we need that information to make it work.

Bill Taylor: This is Bill Taylor. I was interested when you mentioned the possibility of putting a measure into reserve status rather than taking away the endorsement for entirely – it sounded from previous discussions, it felt like there was a lot of reluctance to take an endorsement away because of the possibility that it would be misinterpreted as meaning it wasn't important.

So how about this idea of reserve status? Could we learn a little more about that? Or was that – what are you thinking in that regard?

Helen Burstin: Absolutely. Karen, you do – since you've been doing a fair amount on it, do you want to give a little insight into where we are?

Karen Johnson: Sure. So, reserve status, measures that are in reserve status, they're actually inactive but they are still endorsed. But those are measures that basically pass all of the evaluation criteria except the opportunity for improvement criterion. So basically, they are the topped out measures.

So, what we've done is basically make it very plain that if measures – if a committee decides that a measure is topped out, it would automatically be considered as going into reserve status.

So, we've had more consistency since we've kind of made that more plain because sometimes committees would just completely remove endorsement because there would be no opportunity for improvement. Others would say, you know, it's still really important we don't want to signal incorrectly so let's keep it even though we don't really think that there's much opportunity for improvement.

So we have this reserve status. It actually was available to us and to you guys two years ago, but it just wasn't being consistently applied.

Bill Taylor: I may be alone, I don't – this is Bill again. I don't even remember being part of our discussion when we worried about people misinterpreting as we talk about standards of measures that might get, you know, were up for – having been topped out and we thought it might not be wise to continue and then we'd say, "Gee, if we don't endorse that anymore, then people misinterpret it or think it doesn't matter."

I don't even remember that we discussed the possibility of reserve status. But it sounds to me like an exciting alternative and what might – is there experience with that that the ones that have topped out remain, you know, highly adhered to even when they're put in reserve status?

Karen Johnson: So far, I don't think we have a lot of experience in terms of, you know, do they say topped out. Really, what we've done with the process of reserve status is, we say that it's inactive. So in other words, three years down the road when it's time to think about it again. We won't think about it again unless somebody asks us to.

And one of the reasons that somebody might ask us to reconsider it again and put it on active status, if you will, is because that they've seen, you know, a degradation in performance.

So, I think it's still a little early to know what's happening. I don't – it'd be nice for me to know how many measures we now have on reserve status. I will tell you – and I don't know the answer to that, but we've put a lot more on in the past two years than we had ever put on before. Specifically because, you know, I think you're right, even though it was probably an option two years ago, it wasn't, you know, that we didn't have a written policy somewhere that we can easily get to and remind you guys of.

Helen Burstin: Right, and this is Helen again. Just – I think it's a great question and, you know, the way we've written the idea of inactive reserve status is that hopefully there's an expectation that by not removing the measure from endorsement, but keeping it in this inactive status, ensures that there should be some periodic surveillance overall to keep an eye on whether these otherwise important evidence-based measures that are topped out are starting to show any decrease in performance.

Obviously, if they're removed from endorsement, you know, if a problem comes up later, they have to come all the way back to the – you know, all the way back to the process and we want to ensure these are important measures but ones that need some periodic surveillance to make sure we're not seeing any degradation adherence.

Vicky Ducworth: Hi, this is Vicky. I agree with all of your comments. And as far as the clinical process measures, you know, I still think from the administrative perspective like the Q.I. – the quality directors that are working directly with the providers, having this process measure, it's still helpful to kind of focus the

conversation with the providers around achieving these clinical outcome measures. And especially if we're going to accept that process metrics that are ultimately identified as maybe core commonalities that exist across a population mean of patients with desirable clinical outcomes and relative to a disease category like diabetes.

And then – so what we do then is once we can have this conversation, but ultimately then docs can kind of develop their own treatment algorithms and make adjustments in those treatment (inaudible). One example was like (treatment) versus core chronic care visits. And then administrators like myself, we can go in and really evaluate that point of diminishing outcomes return. And then work with the provider to really customize per the population's (top site) and geography to ultimately develop, you know, kind of out – or models that really support outcomes as well as that are cost efficient, which I think is really critical at least from like the payer perspective and also the patient perspective.

So, there is some value in this clinical process metrics at this time or at least that's how I feel. But not all of them, I agree, so.

Helen Burstin: Yes, it's helpful.

Bill Taylor: This is Bill Taylor again. You would talk about the focus on removing endorsement, and what about that? I wonder if there's a way we can develop a little more focus on the question of unintended consequences.

Helen Burstin: Yes.

Bill Taylor: It seem to me that that was not a particularly robust part of our discussion and is a – I felt a little bit sometimes like a voice in the wilderness is, you know, and it – in the way our group is organized to worry about that, it seemed like, "Well, gee, if we've said this very specifically, what we mean and sort of people who are on their own if they're misinterpreting it as opposed to knowing when you're making endorsement that there will be misinterpretation and worrying about what some of the, you know, implications of that will be."

Helen Burstin: Yes, it's a great point, Bill. And I think it's exactly our desire of, you know, trying to get more out there and getting that feedback and perhaps focusing it specifically on where there might be unintended behavior changes as a result of these measures. And I think that's a lot of what we heard last year as part of that V.A. appeal was that, although the measure is pretty clear about patient populations and comorbidities, behaviors might still be different out – you know, if people may change behaviors, not necessarily directly as a result of the measure, but perhaps, by being worried about glycemic control overall.

So but, you know, thoughts about how you think we could get that information from the field would be really valuable.

Jim Dudl: This is Jim Dudl. Can you hear me?

Helen Burstin: Yes.

Jim Dudl: I wonder about another wrinkle of the topped out. It seems to me that when we were looking at measuring A1cs and we're in the 94th percentile and trying to get to the 96th percentile, that really wasn't very important and yet we were – it was driving a lot of money, it cost us less few percentage. Whereas, you know, if we have above the 90th percentile, about every two years, we get everybody.

I'm wondering if we would say instead of, you know, there's a percentage all the way up, if you're above 90 percent or 94 percent, or whatever, then everybody above that is satisfactory and you just leave it at that. Just another way of saying, if you pull it off and you say everybody above the 90th percentile was – is there, it just takes the pressure off of having to go from 90s and 92 percent.

Helen Burstin: Yes.

Bill Taylor: This is Bill Taylor again. If we could figure out some kind of – and may not be us, but if you NQF, the methodology about how to deal with continuous problems like what's the rate at which a measure adhered to and then the problem of a cutoff where, you know, it's bad below that, it's good above that. I mean, I literally – in the moment before I came into this meeting was in – for

another reason, a meeting with one of my colleagues was talking about what to do about pushing the Pap smear rate in our practice above whatever the threshold was. We're almost there.

You know, there were so many hundred women who we have to get in, do we have some kind of fair, what do we do for the providers to make it worth their while. I mean, from the point of view of society and value, that's a waste of time. You know, if you're at 96 percent, then you want to get to 98, you're going to put a whole lot of effort into what – that's terrible misuse of effort, should go somewhere else because what's the difference between 96 and 97. And yet, on all of these continuous variables, we draw a line because that's our – the best method. There's got to be a better method.

Helen Burstin: I couldn't agree more. And we'd love your thoughts about, you know, again, this is a classic example, Bill, of how that real-world experience is, you know, transformative for us to really understand how we then come up with those rules.

Starlin Haydon-Greatting: So this is Starlin. I'm also a part of the Pharmacy Quality Alliance. And what we do when our measures outlive or need to be on reserve is we have – they have a group of people that voluntarily submit how it's working in their environment, and what the results are in a none – you know, in a friendly manner so that we can actually, you know, see how – do some post-marketing surveillance on, you know, some of those things are – one example was – are the ACEs and ARBs and see how – and sometimes what we've noticed is that in certain populations in the southeast part of the country where there's more African Americans, the ACE and ARB use was struggling but – because it's not the choice for some of the certain populations.

And so, that's allowed us to have some feedback. So we have core groups of – and, you know, it's pharmacy claims so we can go after, obviously, we get PBMs involved and some of the other larger institutions. But, people like Kaiser and, you know, Minnesota has a – is really good at collecting their data and looking at it overtime.

I'm just wondering if you had a volunteer group that would do some post release so that you – we could have, you know, a little test modules to see how it's claimed in the real world, so that you could get a litmus test. Just a thought.

Helen Burstin: No, it's an interesting idea.

Karen Johnson: So let me ask you guys, and this has been really interesting discussion, I had mentioned that some of the measures that you look at seemed to be not getting much higher. And I don't remember which ones they were. I think maybe a couple of them may have been like the foot exams for diabetics.

And I don't remember the exact performance rates. But let's say it was somewhere around the high 60s or 70s, somewhere in that range.

Thinking about – you know, something that everybody should be doing, but knowing that at least in the past few years, you know, it's kind of bouncing around but not really getting much higher. Do you have any ideas about why that might be? Is it that it'll never really get much higher than the higher 70s or 80s? Is it time to think about something different? In other words, you would never look at a high 70s and say it's topped out because it's not close to that 100 number.

But, is there any way to know if that really is topped out that it'll never really get any higher than that? Do you see what I'm saying? And do you have any ideas? I mean, is that a crazy thing to even be thinking about or is it a reasonable question that we should be looking into a little bit.

Anne Leddy: Karen, this is Anne Leddy speaking. I personally feel that every diabetic patient needs a careful foot exam. So this is one measure that really needs virtually 100 percent. And if my memory is correct, the foot exams were not very good in terms of percentages. I think the one area that we really talk about the most of being sort of maxed out was measuring the A1c.

I don't know what the other endocrinologists think about the diabetic foot exam. But it really is crucial for care.

Bill Curry: So this is Bill Curry.

Helen Burstin: Go ahead, Bill.

Bill Curry: So, I think part of the issue with the foot exam is, how does it get captured in data collection to report measures within the institution or within the regional health collaborative, et cetera. So, for many of the electronic medical records, it's not its own separate data field.

So, to be able to search this, there has to be, you know, somebody collecting that data and putting it in a special way where it's got to go in as a CPT II code. And many organizations and practices aren't there yet.

So, capturing the data within an institution or if a patient is having a podiatric consultation, how do we get that data not only in – on a letter to, you know, the PCP or the endocrinologist, how do we get that into the electronic record. So, some of the challenges with these measures are the lack of being able to get it codified within an EMR as its own separate data element.

Bill Taylor: And this is Bill Taylor again. Could I add a cynical (coder) of that?

I see so many consultations from consultants who use a formatted note. I mean, I'm thinking of some neurologists who I trust and see patients of mine. But their notes are useless because they have an unbelievably complete neurologic exam every time they've seen a patient, which the patients tell me didn't get done.

So if we – how much game – is there a way for us to find out about how much the systems get gamed? I mean, the cynical question could be, even if that's at 70 percent, how many of those systems where something gets clicked or patient – or people are prodded to put something in in some way that shows some things that never happened.

We don't want coded foot exams, we want our diabetic patients to actually have their feet examined by somebody who knows what they're doing and will do something appropriate with what they find. And it's a worry with a lot of these electronic systems that are set up to code and, you know, generate

money especially when we're there to tell them what they get paid and not paid for, or paid more or paid less for. That, you know, how much of this is translating into actual improvements of care.

Helen Burstin: Yes, fair question and a very hard thing to get a handle on. And maybe that's part of the, you know, questions around our assessments of reliability and validity, I mean, is that something to consider particularly for the eMeasure space. But I think unfortunately, some of that has become more prominent at least for our practice so just thought of blocking and copying from last notes or starting your notes in the last notes.

Certainly something we can think.

Bill Taylor: It's something empirically answerable, I mean, I don't know that it's, again, up to us to answer but …

Helen Burstin: Yes.

Bill Taylor: … it's certainly would improve, you know, countries got an interest in knowing, is that where we're pushing people to do through the – part of the – not only us but behind the whole way where the system is being run.

Helen Burstin: Yes.

Karen Johnson: Other thoughts?

I have a couple other questions that I teed up and I think we've hit most of these. But I want to spend a little bit of time on the idea of relevance to the full portfolio and actually Helen's already talked about that a little bit.

Maybe the idea that if we have the outcome measure, do we need the process measures?

And that's a – it's a simple question and probably not simple answer. But, is there any way you could help us think through what kind of criteria we might use, and it wouldn't necessarily have to be outcomes versus process. It might be, you know, if you have this process measure, maybe you don't really need these other ones.

Or, you know, maybe if you have – and this is something that you guys opined upon last time, you know you have the composite measure, you know, do we need to endorse the individual measure. Any thoughts on that?

So in other words, just to remind you, we have the criteria that I reviewed with you and we look at each measure kind of with blinders on. You know, that to pass these criteria, this is measure pass, the next one, on and on and on. But then, once you say yes, and that you recommend it for endorsement, we don't go back and say, "Now, in light of everything else that we have in the portfolio, do you still want it?"

So my question for you is, would something like that be useful or helpful, and if so, what kinds of questions or criteria would you think about?

Starlin Haydon-Greatting: This is Starlin. I think that's essential. I think we really do need to do that. And I think you have to start with endpoints and work backwards and see where the crossovers are.

Karen Johnson: Start with what, Starlin, I missed what you said.

Starlin Haydon-Greatting: You have to start with the end – you have to go to the end and work backwards.

Male: Yes.

Starlin Haydon-Greatting: So, if you're …

Karen Johnson: OK.

Starlin Haydon-Greatting: … looking at …

Male: Right.

Starlin Haydon-Greatting: … if you're trying to compare, let's look at what the endpoints were and if you have intersecting circles, OK, was that – did that – is that forced from a process measure or was that from an outcomes measure. And it might

help us feel more comfortable grading that between those two. Or scoring it in some manner.

Jim Dudl: This is Jim Dudl. There's something here that has been a great problem to us inside Kaiser. That I think when we're looking at the endpoint, we tend to really want to focus on heart attacks and strokes or cardiovascular disease.

When you look at lipids, they only look at cholesterol. And when you look at hypertension, you only look at blood pressure. And what we've had to do is bundle in people with hypertension and even normal lipids but high CVD risk to bundle lipids and an aspirin with that.

And when we do that, we get really big drops in heart attacks and strokes. But nobody really kind of – you know, the hypertension people don't push the lipids. If you really – when we look at MIs and strokes, that's when we said, "Oh, it's not good enough to treat the blood pressure. It's not good enough to treat just the lipids, but to do the bundle."

And if you drop MIs and strokes, even if your lipids didn't drop a lot, or your blood pressure didn't drop a lot, you're actually getting at the 90th percentile of what you were trying to do when you treated those two things.

So, I think it is important to look at the ultimate outcome hereafter. And then consider, you know, how much of the other process measures you need and interim outcomes you need.

Karen Johnson: Other thoughts?

Bill Taylor: The implications of that – this is Bill Taylor again. The implications of that are huge, right? I mean, the reason we're treating people's diabetes, you know, was integrated into all of these other things to try to reduce the risk of the complications thereof, right, which are not only high and low blood sugar. So …

Jim Dudl: Right.

Bill Taylor: … you know, if we really thought about and took that seriously, we would harmonize, you know, beyond all of the diabetes measures to the whole bundle. I mean, it's everything, right?

Jim Dudl: You know, if you really look at morbidity and mortality, clearly cardiovascular jumps way above everything else. And then when you look at that, the simplicity of just saying, start the (mono-statin) and an aspirin, and an ACE/thiazide and your 75 percent there, you know, all of a sudden becomes very easy.

Bill Taylor: The poly pill.

Jim Dudl: Exact – well, and just poly pack, you know, you can do poly packs easily. And poly pills, I think, are coming.

But, seriously, it's really the ultimate outcome we're after and I have such a hard time telling people with hypertension to think about a statin. Cholesterol is only 100 or 90 or whatever, but yes, the statin actually has the most powerful – has the most powerful drop in heart attacks and strokes in the hypertensive person without dropping the blood pressure. You know, you're not going to use it alone, but the point is you really should not be missing it.

And people are not really focused on that and they do miss it.

Female: So …

Bill Taylor: Or the people to quit smoking, right, so how do we integrate into the much bigger picture, and we're set up as the Endocrine Committee and then we talk about diabetes, which is great. But I think this issue of more integration for the purpose of what we're really here for about health would be phenomenal to somehow get on our radar.

Starlin Haydon-Greatting: Well we do have many quality measures that address statins and treating hypertension and looking at renal function, every single one of them is important.

Bill Taylor: Yes, but we don't – when we make an endorsement about something about checking A1c or a foot exam, we're not necessarily as we think about, you know, does this make sense with the whole package. How does it – does this add to health, you know, and the burden of what we're doing with this general topic at the beginning of reduction to a reasonable number of measures. We should be thinking – I would hope we're thinking broadly.

Jim Dudl: It was when we started focusing – because we have heart attacks and strokes. When we started focusing on the fact that, yes, we did drop cholesterol a little with whatever, blood pressures some, but our heart attacks and strokes were still increasing. That's when we decided we had to be careful to do all of the measures and when you put them altogether, it was actually pretty easy.

It's just – it's something that I think, you know, if we focus on heart attacks and strokes, that is really what we're after, then I think people begin to look at all of things that work.

James Rosenzweig: Well, this is Jamie. I think there's an overlap between some of these issues especially when you get to prevention. I mean, we're talking about eventually looking at more measures related to metabolic syndrome, but also prevention of diabetes overlaps to a great extent …

Jim Dudl: Right.

James Rosenzweig: … with prevention of cardiovascular disease.

And you know, the outcomes might be a little bit different, in other words, you might be looking at the number of people who developed diabetes within a certain population overtime as opposed to cardiovascular disease, but the actual way – the actual process is to achieve those goals could be one and the same.

Helen Burstin: Yes, and this is Helen again. I just wonder, maybe one opportunity might be in this sort of opportunity before we hit you guys with a lot of measures. It might be a really interesting discussion to pull this group with the Cardiovascular Standing Committee together.

Again, they say so many of the same issues about comorbidities as those measures come up for hypertensives or patients around hypertension or lipids. It might be interesting to get some cross-fertilization going there to really think about how best to approach these issues. I think they'd enjoyed it as well.

Jim Dudl: Sure.

Karen Johnson: Yes, I think it would.

Helen Burstin: Yes. OK.

Starlin Haydon-Greatting: Also with Medicare approving diabetes prevention programming now …

Helen Burstin: Right.

Starlin Haydon-Greatting: … that's going to be a measure rich environment.

Helen Burstin: Absolutely. That's great idea. Yes.

Karen Johnson: OK. We didn't go through every one of these questions, but I think we touched on almost every one of them.

Just real quick, we've got a couple minutes here. How about – and we've had other people give us input on this question, but I was curious as to what you guys would say. Endorsement for eternal quality improvement versus endorsement for accountability purposes, things like public reporting or for payment.

Right now, measures NQF endorsed, we are saying that it's suitable for either of those two applications. We do think it would be beneficial to have some measures potentially endorsed only for the Q.I. side.

And if so, would those be the – you know, the process measures that we've been talking about.

James Rosenzweig: This is something – this is Jamie again. This is something that has come up repeatedly over the years. And to my mind, especially with respect to clinician accountability, there are certain measures that are more valid to be used for accountability than others. And some – so that I would think that there is actually a difference between the two and I had thought that NQF was moving away from purely quality improvement measures just to accountability, but I think that's actually an important issue.

Helen Burstin: Yes, this is Helen again. It's something we've really struggled with. I think, you know, there are a lot of measures out there that are Q.I. measures. Some of which could be appropriate for accountability.

I think what we fear most is (whether) there are two many accountability measures out there that, in fact, do nothing for quality improvement. Would it be useful at least to collect the Q.I. measures perhaps even if we didn't dive deep and do the full criteria just so everybody doesn't reinvent the wheel every time they need a Q.I. measure. So we'd really welcome your thoughts on that today or in the future.

Karen Johnson: Yes. Unfortunately, none of these questions are easy, that's why we wanted to ask you guys, to see if you had some good thoughts and there were several things that you guys said over the last 45 minutes or so that have been – I think that give us some ideas on things that we could potentially look into.

Again, as, you know, you go about your daily work and something occurs to you that kind of hits on any of these questions or points, drop me an e-mail, I'd love to continue getting your thoughts.

Bill Taylor: One – this is Bill again. On the Q.I. versus accountability, isn't part of it the sort of sample size problem? I mean, you can't judge me as a clinician, the outcomes of my patients because I don't take care of enough patients to know, you know, whether my actions are actually improving their health as was just said, you know, strokes and MIs and so on. But if you're looking at Kaiser and you want to know, are they doing this, as we just heard, I mean, if you can reduce strokes and MIs …

Helen Burstin: Yes.

Bill Taylor: … that's what we care about. So, isn't part of this question about Q.I. and accountability you wanted to use for sort of the slave to the – you know, the sample size problem?

Helen Burstin: Yes, or the level of the analysis, right. I mean …

Bill Taylor: Yes, yes, yes.

Helen Burstin: … that's a big difference to what you can do at the individual clinician level versus the system level certainly. And I think our experiences, the higher you go in aggregation, the easier it is to get to some of those tougher outcomes even patient-reported outcomes in a way that makes, you know, (use for a meeting).

Starlin Haydon-Greatting: This is Starlin. This is a slippery slope. So if you have an EMR system that is checking out box and filling in the gaps, you've got – if you're using it for accountability, you've got to have a process of measuring that that is – has not been in a digital check-off box.

And when you drive – so we've seen it in pharmacy, as you drive accountability, you drive paper work that looks great but not necessarily what is happening at the front end, at the patient level.

So I mean – so again, we have to go back and look at those measures and how they work in a real – like in those different populations and what that expectation is, and then you're hoping that the person who adapts that is applying the same scientific principles to it.

Right now, the PBMs are using all the PQA measures for quality and they're – restrict their charging DIR fees to pharmacies and even though they're in the 90th percentile range for quality, they're holding back money based on what their predictability is.

And so, my question, if a PBM is, again, using this for their own purposes and not really making sure that the patient is getting the quality measure that we are looking at. And one example is patients with diabetes on a statin.

And so, that's a great measure that's – quality measures that's really working well and it's really doing something great for our patient population. But then – on the payment side, you got a PBM, you know, dinging you in DIR fees because they're manipulating the numbers. So, it's something that we have to get a really good framework on.

Helen Burstin: Yes.

Starlin Haydon-Greatting: And I think as our EMR gets better and there is more interoperability, I think that's going to be better. But like what we talked about earlier, there's just – it's just not – it's not perfect yet. There's just a lot of, you know, notes that aren't really replicated and even though we have ICD-10 that's expanded, it's almost made it more confusing. So we're still in the mode of, it's getting better and it's not what it looks like 20 years ago, but it's not perfect yet, so.

Karen Johnson: OK. Well, this has been really a good conversation for us here at NQF and we do appreciate it. We want to open up the lines now for public comment just in case we have others who are listening in.

So, (Bridgett), would you open up our line and see if we have anyone who wants to make a comment?

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

And we have no public comment at this time.

Karen Johnson: Thank you very much. So now for next steps. In terms of our off-cycle webinars, as I said, let's go to the next slide, we'll be doing them quarterly. So, we'll have three more in – that I know of and possibly another one the last quarter of 2017. So, what, we still have to do solidify topics and potentially speakers. There's, you know, there is opportunity to have somebody besides just NQF people talking.

So, again, if you have ideas on things that you think would be a good topics for our group, let me know. And Jamie and I will finalize those hopefully in the next few weeks or so. We'll have a good idea of what we want to do.

And then we'll be sending out those lovely doodle polls to you because you guys are busy, and we want to get this on your calendar as soon as possible. And then once we figured out, you know, the best date and times to get the majority of you on a call, we'll send out the actual invite.

So, with that, does anybody have any questions for me or for Helen while you have her on the phone about anything that we've talked about today?

All right. Well, according to my clock, I'm going to give you back about four minutes of your day. Thank you so much for joining us. I enjoyed hearing you guys all get together and talk about these things with us. I appreciate it very much. Have a great day.

Male: Thank you.

Male: Thank you very much.

Female: (Thank you).

Female: Thanks.

Karen Johnson: Bye.

Female: Thank you.

END