National Quality Forum

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OPERATOR: This is Conference #: 83524660

Operator: Welcome everyone. The webcast is about to begin.

Please note today's call is being recorded. Please standby.

Shaconna Gorham: Hello, this is Shaconna Gorham and I'm here with my colleagues, Vy Luong and Reva Winkler. We would like to welcome you to Eye Care, Ear, Nose and Throat Conditions Standing Committee Call workgroup number three.

Today, we have workgroup member Scott Friedman, if you could just give a quick hello.

Scott Friedman. Hello.

Shaconna Gorham: And Andrew.

Andrew Schachat: Andrew Schachat here. Thank you.

Shaconna Gorham: And Steven.

Steven Strode: Steven Strode. Thank you.

Shaconna Gorham: All right. And Richard Madonna, have you joined yet?

Richard Madonna: I am here.

Shaconna Gorham: All right. So we have all of our workgroup members.

And then we have several developers on the phone. So AMA-PCPI, if you are on the phone, can give you give a quick hello. No? OK.

Jamie Jouza: Hi, yes, this is Jamie Jouza from the AMA-PCPI. I think that I have other colleagues who are supposed to be dialing in as well.

Shaconna Gorham: OK, Jamie.

And the American Academy of Ophthalmology. (Rebecca), are you on the line.

(Rebecca): Yes, I'm here.

Shaconna Gorham: Do you have colleagues with you as well?

(Rebecca): I think so.

Peter Robinson: Yes. Hi, this is Peter Robinson.

Shaconna Gorham: Hi, Peter. Thanks for joining.

And then, do we have any of the CMS team, the (contractor for) CMS.

Dan Roman: Yes, hello, this is Dan Roman with the National Committee for Quality Assurance, part of the Booz Allen Hamilton team that developed the measure for CMS, yes.

Shaconna Gorham: OK.

Female: Great.

Female: Good to know.

Shaconna Gorham: All right. So, we will go ahead and get started with our consideration of candidate measures. Reva.

Reva Winkler: Sure.

Hi, everybody and thank you very much for joining us.

Today, we're on the third of the four workgroups for this project. The purpose of this workgroup call is multifold. First, we want the workgroup members to be able to share some of their early ideas about the measures, ask any questions about the measure evaluation criteria and how to apply it, as well as ask any questions of the developers to clarify any information that was provided.

And so this is an opportunity to kind of run through things before we get to the in-person meeting, so that everybody is comfortable with the information, the measure evaluation criteria and the measure evaluation process. So, this is meant to be an informal call. So, if you do have any questions at any time, feel free to offer them. I'm just going to be facilitating kind of moving us through the agenda.

We have five majors for this workgroup that we want to discuss. That puts at about 20-ish measure minutes per measure. And since we do want to get all five measures, I'll be watching the time for us.

So, we're going to start off and go in the order on the agenda.

And so the first measure we're going to look at is measure 0087, Age-Related Macular Degeneration, Dilated Macular Examination. This is from the American Academy of Ophthalmology. And it's the percentage of patients age 50 years and older with the diagnoses of age-related macular degeneration who had a dilated macular examination performed, which included documentation in the presence or absence of macular thickening or hemorrhage and the level of macular degeneration severity during one or more office visits within 12 months.

This process measure is intended for use at the clinician individual or group practice level.

All right. So, our – the lead discussants for this measure are Scott Friedman and Richard Madonna. And so, we'll go in order of the measure evaluation criteria starting with the two sub-criteria under importance to measure and report. And the first one being evidence. And so, we are looking for the evidence that relates this process of care with patient outcomes.

So, Scott and Richard, I think we'll just have you kind of share, presenting your initial thoughts and then the other workgroup members should feel very free to jump in and ask questions or share your ideas as well.

So, perhaps, Scott, would you like to start your thoughts on evidence for this measure?

Scott Friedman: Sure, of course.

Scott Friedman. Just to refresh everybody's memory, I'm a private practice practitioner actually specialized in retina. So, I have a lot of expertise with this disease and this measure.

So, age-related macular degeneration is the most common cause of vision loss in adults over 75. Although we see signs in patients over 50. And we're looking to decrease the risk of vision loss and people with AMD, specifically wet AMD or (exhibited) AMD.

So, earlier diagnosis may be beneficial.

And so, in order to treat it, you have to diagnose the severity of the degeneration. And part of that, to facilitate that would be to look in the eye and document the level of retinopathy. Specifically, the severity of the retinopathy whether there is thickening or hemorrhage which points to a more severe type of age-related macular degeneration.

Although there – and there's ample evidence showing that treatment – treating it when you develop age-related macular generation increases the risk of vision loss that's been going on for decades now.

And different levels require different treatments. So in order to diagnose it, you obviously, a priority, have to look in the eye and document the finding.

And so, even though there's no direct evidence that looking in the eye prevents vision loss, it just goes without saying that if you look in the eye and you document that, it much more likely to catch at a specific level, and/or give the appropriate treatment.

So, the evidence is there that documentation and specifically looking in the eye and documenting it will, obviously, most likely lead to better outcomes.

Reva Winkler: OK. Thanks, Scott.

Richard, any additional thoughts?

Richard Madonna: Well (inaudible) well said summary of the measure.

One of the questions I have regarding looking in the eye part is, you know, this is supposed to be a dilated exam, but it's not specified as stereoscopic examination, which I think is critical in trying to detect subtle signs of edema or corneal neovascularization.

So, I think that that's something that at least should be considered as part of this. The question, of course, would be, how we would be able to get it back in the way that the measure is written, in the way that the measure would be followed. That's, perhaps, the biggest thing I have to add to what Scott just said because he did some (inaudible).

Reva Winkler: OK.

All right, that's the – that does speak to the specifications of the measure.

So in terms of evidence, I think Scott mentioned that there isn't a lot of direct evidence for the examination alone in the absence of the subsequent treatment. Any thoughts from any of your workgroup members?

Andrew Schachat: This is Andrew Schachat.

I think there is some evidence that dilated diagnosis is associated with – for treatment outcomes. So that's in really all of the anti-VEGF studies, where patients who entered the trial at better vision – the entry level of vision is really the key predictor of the outcome. So patients who start with better vision keep better vision, and patients who start with worse vision end up with worse vision.

And, looking in the eye is the first step to making the diagnosis. So, although there haven't been trials of doing eye exams versus not, there – I think that the linkage to me is pretty clear.

Reva Winkler: OK, Andy, thank you very much.

Any other thoughts from anybody else?

Scott Friedman: It's Scott Friedman again. As far as the stereoscopic, you know, I think that's the standard of care in 2015. I'm not sure there's any ophthalmologist – a reason ophthalmologist doesn't do a stereoscopic exam, and you can get in semantics now. So you do a stereoscopic exam or what your definition of stereoscopic. There's different levels, variety, and I think it goes without saying that if you're going to do a dilated exam, you're going to look at the eye stereoscopically by definition.

Reva Winkler: OK.

Scott Friedman: I don't think if that's a huge point that we need to (hop on).

Reva Winkler: OK.

Steven Strode: This is Steve Strode, and I'm the family doc in the group. Certainly, there are ICD codes for macular degeneration and CPT codes for doing a retina macular exam, would the CPT code alone, they'll be able to speak to the degree of documentation that we want to come out of this as to whether the complications are present or not and their severity. Or ...

Reva Winkler: Yes.

Steven Strode: ...is that something that we just can't extract from that coding data yet?

Reva Winkler: Steve, I think you're looking at the degree of specifications and I think certainly, we want to look carefully at – yes, you might have jumped ahead just a little bit, so just hang on to that thought for just a second because I think it's an excellent question that everybody is clear on.

But, if we – if we're OK on evidence, anybody have any additional thoughts, I'd like to just quickly move onto opportunity for improvement and then any issues on disparities.

So, Richard and Scott, any thoughts there?

Scott Friedman: Sure. So, Scott Friedman again. The – if you look at the data that was presented by the American Academy of Ophthalmology, the (aggregate) and mean performance results from 2009 to '12 was arranged from 94.4 to 96.1. So, it's very high, and that 90 is – out of the percentage of people that reporting the rate performance results are extremely high.

But, this is a very, very common disease and all the individual – all the eight individuals and it leads to – it's the most common cause of legal blindness again in a (dealt) over 75.

So they even improve from 95, a mean of 95 to a mean of 96 or 97 would potentially save vision in thousands of patients with macular degeneration. So I think even small – even in small changes in mean performance rate results in a large absolute level of decreased vision since it's – it is such a very common cause of vision loss in adult, in older adults.

Reva Winkler: Thoughts from anybody else from the workgroup?

Andrew Schachat: This is Andy again. I found the 95 percent, 96 percent rates unbelievably high.

And, in reading some of the background information that I think came along, I think it turns out that about one-third of ophthalmologists were choosing to use this measure.

And so I think the rates in the ones who were using it might be high. But two-thirds aren't. So there is a huge opportunity for improvement here by getting people to use it. And I think there are going to be few enough eye measures available to ophthalmologists that once these things are finalized, more and more that we're going to find they're going to be forced to use these if they want to select eye measures for the pay-for-performance benefits.

So, I think in the people not using it, the scores – it would be much lower and I think there's a nice opportunity for improvement here.

Reva Winkler: OK. All right, anybody else?

Scott Friedman: Yes, again, Scott Friedman. And I do want to dominate the call, but again, probably – I don't know if there's direct evidence in this and maybe the academy can chime in. But, presumably, the most likely number of people that reporting this would be the specialist i.e. retina because the general ophthalmologist have other measures to report, and if they're forced to use this, again, that they (interject it) and maybe lower.

But, again, even a small change in this number would be a tremendous asset to the people with early macular degeneration preventing vision loss.

Reva Winkler: OK. Sounds good, guys.

Any objection to moving on down to the next set of criteria around scientific acceptability?

We're talking about, first, reliability. And reliability has two aspects to it. One is specification. So Steven will get to your question. And then the other is empiric testing for reliability.

So, the first one, Scott and Richard, how about specifications?

Richard Madonna: Steven, could you repeat what you had said before, I had a comment on it and I held it and now I forgot what I wanted to say.

Steven Strode: Sure, and I apologize for giving out ...

Richard Madonna: No, no, that's OK.

Steven Strode: We know that age is clearly defined, we know that there are ICD codes for macular degeneration.

Do the CPT codes that would specify that the exam of the macular (inaudible) are done? Let us have any information about the degree of documentation that we desire and that is the presence or absence of macular degeneration and the severity if it's present.

Richard Madonna: I guess I'll start with a comment and then ask the retina specialist to chime in on this. But, you know, we do have CPT codes, 92225 and 92226 extended ophthalmoscopy, which does require a withdrawing but doesn't, again, necessarily say that it's stereoscopic exam. But I certainly agree with the comment before that anybody who's really examining the macular properly would certainly be doing this stereoscopically.

So I guess the answer is yes to that question. And I'll throw that back to Scott and ...

Scott Friedman: Well, the answer is actually no, extended ophthalmoscopy would be mostly looking at the (proper) retina, the macular degeneration special vision in the center, so you could do (interior) ...

Richard Madonna: No, I'm not. So I've attended some that have been very interesting in regards to that, and they have really – in the meetings that I've been at, they've kind of said that it's not a peripheral exam, it could be just about anything which I guess can make this – this can muddy the waters a little bit.

Andrew Schachat: Yes, it's Andy. I don't think a lot of people do the extended ophthalmoscopy, I'm not sure. But it didn't occur to me that that was the intent of how to score this. And I think that there's a CPT code that's been created that says, "I did a dilated exam."

And I think the idea is to drop that into your superbill to show that you didn't.

Reva Winkler: Right.

Andrew Schachat: I think the question on the table is, does that mean that you've documented the level of – the correct level of retinopathy that leads to some action. And no, that doesn't show that. But the rest of your coding can because your code, either dry or wet AMD, presumably, it doesn't allow you to differentiate whether it's advanced dry AMD because the ICD-9 codes are all the same for the level of dry AMD. But in the ICD-10 environment, there are separate codes for that.

And I don't think this measure would come out until – I mean, doesn't ICD-10 start in October or something, I don't know.

Reva Winkler: Yes.

Andrew Schachat: So, I think this will work trying in ICD-10.

Reva Winkler: All right. Yes, this is Reva. I just would ask the measure developer if you wanted to clarify how the measure is calculated using the CPT Category II Code that – for this measure. Be sure everybody understands how the measure is calculated.

Peter Robinson: Sure. This is Peter from the academy.

So, as was kind of alluded to in the conversation, so the CPT II Code is really used by the clinician to attest that they actually met the quality action described in the (inaudible), so that they did perform a dilated macular exam and then the medical notes that they documented the presence or absence of macular thickening or hemorrhage and the actual level of severity.

The ICD-9 and ICD-10 codes do correspond to either wet or dry macular degeneration but it doesn't necessarily correspond to the level severity. So again, it would be that the provider had documented those findings and the medical notes and that by keeping this code that we're essentially attesting to that (fact).

Reva Winkler: OK.

Any other questions or discussion about the specifications from the workgroup?

So Steven, were your questions addressed?

Steven Strode: Yes, thank you.

Reva Winkler: OK.

All right. So the other aspect of reliability is empiric testing of reliability. And, the testing could be at the level of the data elements, or it could be testing at the level of the measure score. And in fact, the developers have presented us with testing at both levels. One measure score reliability using a signal to noise analysis, using data from the IRIS Registry.

And then also, data element reliability tested by inter-rater reliability in a single ophthalmologist's office reliability of the claims versus the gold standard and also reliability of the H.R. abstraction.

So, Scott and Richard, your thoughts on the empiric reliability testing.

Scott Friedman: Scott Friedman again. I thought the testing was high as the academy pointed out. If you look at the data that was presented, the (inter-abstract) reliability testing was extremely high. The denominator reliability testing for the (diameter) was 96 percent. The numerator was slightly lower at 45 and that would be moderate, I believe. But it was still adequate enough for this measure.

Reva Winkler: Yes.

Thoughts from the other workgroup members?

Scott Friedman: (Inaudible) of all that, and then to (EHR) was backed up to – the numerator was backed up to 97 percent, it is extremely high.

Reva Winkler: Someone had a question? Comment?

No? Any other thoughts on reliability testing?

All right. For those of you who are ophthalmologists who were maybe measured on this using this measure, do you feel comfortable on the reliability, probably some ground level reality testing?

So, the other aspect of scientific acceptability is validity. And, the – one of the questions to consider is how well the specifications match the evidence that you've looked at.

Also, empiric validity testing, while we would love to see much more empiric testing, we're finding that that is not quite where measure developers – measure development is yet and so we do accept the systematic assessment of face validity which was presented here.

Richard and Scott, any comments on validity testing?

Scott Friedman: No, again, I don't want to dominate the conversation. But, the face testing you suggested was performed with an extra panel and the results show that the measure was (out), the validity was high. And I think that's adequate for my (needs).

Reva Winkler: Right. OK. And NQF as well.

However, in the absence of any other empiric testing, the highest you should rate based on just face validity should be a moderate rating. It does take empiric testing to get the high rating.

Threats to validity or something to be considered. In terms of things like exclusions are appropriate, populations included or appropriate exclusions, this measure is not risk adjusted so it's a process measure so that isn't particularly applicable.

We did see data provided, it was updated last week in terms of the 2014 measure results from the providers in the IRIS Registry showing the distribution percentiles, the interquartile range to see how well the spread is in performance for this measure. You're asking yourself, "Can this measure be used to make comparisons among providers?"

And so, any thoughts or comments from the workgroup members on any potential threats to validity for this measure?

Scott Friedman: No, it wasn't – it's not risk adjusted, basically, everybody can be – you're not screening up people which is good, I mean, so in theory, someone comes in saying, "I don't want to have a dilated exam", for whatever reason, you don't (seem that use) take them back next month and they (inaudible), that's an appropriate exclusion.

Other than that, we're including everybody, which is perfect in these measurements.

Reva Winkler: Right. Thoughts from anybody else?

Richard Madonna: Yes, exclusion is kind of allowed the performance to better reflect what's probably happening in the real world so I don't see – as Scott just said, I don't see any real problems with that.

Reva Winkler: OK. Thoughts from anybody else?

Bill Rich: Yes, Reva. This is Bill Rich.

Reva Winkler: Oh, hi.

Bill Rich: Hi, Reva. You mentioned the ability to compare among providers, and I think Andy Schachat, of course, that this measure is mostly done by retina people.

And IRIS sort of actually able to compare the performance of all measures from eligible providers and there's huge variation from 30 percent to 99 percent.

And so you're looking at – at the started year, when you're looking at claims data, because you're only looking at three measures that were selected, and also with IRIS, claims reporting is really over for specialties in 2015. You just can't report nine measures across three domains.

So basically – and these are going to be reported for our profession through the IRIS Registry. And actually, you have a real time feedback, your

performance to benchmark of all measures, both (QCER) measures and PQRS measures. And you can really see the variation within your own practice and across the whole population.

So, I think that we're actually looking at the claims base and probably not going to be (remained) for this year because just something to keep in mind.

Reva Winkler: Right. Thanks, Bill, very much. I know that you've been working to really bring IRIS up to real high level of performance and its promise is sounding really wonderful.

So, thanks for providing the data that you did to show how it's being used at this point in time.

All right. Any other thoughts from workgroup members before we move onto the next criteria of feasibility and then use and usability?

So, feasibility is typically around the data source or data sources depending on how the measure is specified. But it's really an evaluation of the burden and how readily available the measure can be done using electronic sources which are presumed to be less burdensome.

So, Scott and Richard, any thoughts on feasibility of this measure?

Scott Friedman: Well, the feasibility, I mean, and back in the old day of paper charts, you document the findings, you put the appropriate CPT II Code in and if you get out of it, it's written there.

And with electronic health records and the registries, it's even easier for us to document the (inaudible) everybody, they just don't represent in my patients. And the developer can maybe chime in on again, it's extremely easy to get this information and the use with the IRIS Registry or presumably any other registries but I use the IRIS Registry and this is a no-brainer, the feasibility is as simple as you can make it. (Inaudible) for measuring.

Reva Winkler: Great. Thoughts from anybody else from the workgroup?

Andrew Schachat: I agree with specific CPT code to show this. It will drop right out of the electronic claims data.

Reva Winkler: OK.

All right. Any other comments or thoughts from anybody around feasibility? Then we'll go to use – usability and use. I think it's been discussed, this measure is used in a PQRS program. There – PQRS will be moving forward with public reporting of the measure in the near future as well as value-based payment modifier and then this is also collected through the IRIS Registry. So, currently, definitely in use.

Scott or Richard, any comments on use and usability about the measure?

Richard Madonna: Nothing to add to what you just said.

Scott Friedman: Yes ...

Reva Winkler: Yes.

Scott Friedman: ...you said it all.

Reva Winkler: Yes, I mean, it's – these are pretty straightforward, I think.

Any comments from anybody before we move onto another measure?

And I think you're going to find as these measures are somewhat clustered as some of our comments will – we won't need to repeat ourselves over and over.

So the next measure is measure 566, also about age-related macular degeneration. And this is counseling on antioxidant supplements. Again, from AAO and this is the percentage of patients age 50 years and older with a diagnosis of age-related macular degeneration, or they're caregivers who were counseled within 12 months on a benefits and/or risks of the AREDS formulation for preventive progression of AMD.

So, another measure in this topic area, and our lead discussants are Richard Madonna again and Steven Strode.

So, guys, what do you think about the evidence for this measure?

Richard Madonna: This is Rich. So I guess I'll start.

Scott described AMD and the importance of appropriately managing AMD before, so I don't think we need to backtrack and go over that.

Really, we're discussing the results of, first, the AREDS study and then the AREDS2 study to major randomized clinical trial so we certainly have randomized clinical trials to rely on here.

And so, the question really becomes, as you said, the description of the measures, the percentage of patients age 50 and older with the diagnosis of AMD, whether caregivers who were counseled within 12 months on the benefits or risks of the AREDS formulation to prevent the progression of AMD.

I think the issues that we have to look at here as we look at the evidence is the nature of the counseling and who gets it, because we're just – we want to look at everyone that's being counseled but within that group and looking at the results of AREDS, we know that the AREDS formulation is only directed at persons who have either group three or who were in group three or group four of AREDS.

So, the majority of patients will not be in groups three or four and will not be fit to have an AREDS formulation recommended to them.

So the majority of patients we're going to be talking to are probably people we're going to be saying, "This isn't for you." And so I think that's one of the issues we have to look at.

Additionally, part of the counseling would be to talk to patients like smokers who should not be on the AREDS formulation.

Additionally, we now have new data from AREDS too and we need to recognize how that fits in.

And finally, I wonder how genetics will fit into this as well as we go forward and this is probably something we'll discuss maybe in a few minutes as we look at some of the other parts of this and get beyond the evidence.

So, I guess to simplify what I said, we do have two randomized clinical trials, AREDS and AREDS2. So, we really need to look at how to best utilize the information from those studies.

Reva Winkler: Great. Thanks.

Steven, any thoughts?

Steven Strode: Yes, it strikes me with this measure is some others that we find kind of have to say ultimately we rely on common sense and hope. We've got the good studies that would say for the subgroups as Dr. Madonna mentioned that the supplements will be helpful. We don't have proof that counseling is going – has been shown to reduce the complications. But I think there's every reason to think it's logical and sensible to depend on that hope and common sense and encourage and document that this counseling takes place.

Reva Winkler: OK. Thoughts or comments from other workgroup members?

Scott Friedman: Andy, you want to speak now or you want me to speak now?

Andrew Schachat: Oh, you go ahead, I'll wait.

Scott Friedman: OK. So, Andy's name was in here so I can see it right there, interesting, he's on one of the papers, maybe the lead author.

So, AREDS, AREDS2 came on a few years ago, the issue of smoking and (inaudible) was in there and they took out that so that's not a problem anymore.

So basically, there's good level one evidence that with moderate to severe macular degeneration bottom in, they're helpful. And we know that in mild macular degeneration or no macular degeneration, where we talked particularly with my (old) that it's not beneficial.

So, the academy succinctly and carefully chosen the word counsel because you want to tell the patients that you have this level of macular degeneration that sign shows that at this level, basically bottom in, specifically AREDS2 or no benefits to take them. I tell my patients, "You can take them if you want, but there's no proof and benefit."

But with moderate to severe, there's definitely proof of vision saving over five years. And even – you know, at some point, you have to tell the patient that you should take them and that's the counseling part of it. So, people, even though it's a small number, you're still going to save lots of vision if you tell patients that AREDS2 are beneficial and also concomitantly tell patients with mild macular degeneration that they're of low benefit.

And I still think that that's beneficial. You documented it, and the patients know what the course of action is.

Reva Winkler: OK. Anybody else?

Andrew Schachat: Well, so, it's Andy. I'm fine with the measure, but I don't really like being encouraged to tell patients not to take vitamins because I try and save time and not have the discussion if it's not really appropriate. If they have a question about vitamins, I explain why it's not useful if they're an AREDS2.

But, just two comments about that. One is that the (Beckman) classification, which is a slightly different classification, getting away from the AREDS categories of talking about macular degeneration, recognizes that and is trying to talk to patients who have the mild, these forms of macular degeneration as if they have aging changes and get away from having to discuss that they have macular degeneration.

Another comment is, this will all work out in ICD-10 if you only want to counsel the threes and fours and if you want to change the measure a little bit in a future year, because in AREDS (10), you can differentiate levels two, three and four whereas you – well, at least two and three, whereas you can't in ICD-9.

Anyway, I support the measure.

Bill Rich: You know, one point ...

Reva Winkler: OK.

Bill Rich: Reva, one quick thing, this is Bill Rich again.

There's an article out of National Eye Institute that said that over five years, if appropriate, counseling (were given), you would save 300,000 patients for study. It saved 300,000 people in the U.S. since developing what is known as wet macular degeneration.

So not only are you finding blindness, but you're actually looking at savings if you can defer the use of anti-VEGF agents, somewhere between $2.72 and $9.17 billion over five years. So, this measure actually has some level one evidence that it actually does prevent the progression of disease, and save society a lot of money.

Reva Winkler: Super. OK. All wonderful things, great.

Thanks, everybody. Really good contributions to the discussion. Anybody else want to say anything about evidence?

OK. Then let's go down and look at opportunity for improvement. (One B) again, we've got the data from PQRS as we did with the last measure. Similarly, it's a small proportion of providers reporting. Comments, Richard or Steven, on opportunity for improvement.

Richard Madonna: I'm not sure if this is an opportunity for improvement, but I'll put out there anyway.

You know, I just think about that – the word counseling and how it's used and, you know, I guess in some ways, to me, counseling is not as simple as just saying you are eligible for supplementation. I mean, this – yes, actually, AREDS and AREDS2 were kind of – there are some complexities to the results.

And I guess I wonder somebody checking off counseling whether they truly are familiar with the actual results and recommendations for AREDS.

Again, I don't know if that's just an editorial comment or an opportunity for improvement, but I thought I'd mention it and I just wonder, you know, particularly how the retina specialists feel about that sort of thing.

Scott Friedman: Can you be more specific about your question, so – I mean, it's unclear to me. Andy and I do this everyday, we do this for a living and it ...

Richard Madonna: Right, exactly. And that's – but the measure isn't, I guess, just totally directed at you guys who probably know the results – certainly know the results better than anyone.

You know, I just wonder if everyone has looked carefully at who checks off they have counseled patients, whether they're really giving them appropriate counseling. I mean, you know, if somebody in group one or group two should – there's no evidence as to whether a supplementation is beneficial, yet, are they really being told that.

So as I say, I'm not sure if this is an editorial comment or an opportunity for improvement, I'm just ...

Andrew Schachat: I think it's the latter. I think that – it's Andy. I think we don't know if doctors are telling patients the right things, but I think you're pointing out an opportunity for improvement by having a measure such as this. But if doctors who may not know a lot about AREDS are going to learn a little bit and then hopefully, you're going to ...

Richard Madonna: Hopefully right.

Andrew Schachat: ...to this measure.

Scott Friedman: Yes, I agree. I think it's the latter, I mean, obviously, there are maybe people that are recommending AREDS2 vitamins and they have more moderate levels of degeneration but you hope it doesn't happen. And certainly, I don't think this measure addresses that, we're kind of assuming that people have an

expertise in the disease process and they can make the appropriate counseling based on the data that's out there.

Richard Madonna: OK.

Scott Friedman: The evidence at that point.

Steven Strode: Steve Strode. In terms of what studies would you like to see done, it would be great if there were studies that said, looking at the goal of an informed patient or caregiver, these are the methods that were used and these are the wonderful results that we had in their education.

That's really complex and that's not where research money goes.

At the least, I would wonder if the specialty organization, AAO, or the sub-specialty organization of retina practitioners might at least develop some educational materials that would be aimed at a particular literacy level materialistic, and make those widely available to the ophthalmologist and retina specialist to help with this important aspect of practice?

Scott Friedman: The AAO has a preferred (structured) pattern which is better on for decade, which is always being updated, which in my opinion is just a tremendous asset, it's available for all the academy members, it gives a very good summary of macular degeneration and all of the evidence and development of evidence and all of the epidemiologist treatments, et cetera.

And that's always available. The academy in my opinion bias (in it). So the tremendous amount – the tremendous job in education, including they're not limited to the preferred practice (primary).

Steven Strode: That's great.

Reva Winkler: OK. All right. So, if everybody is OK, we'll move onto the scientific acceptability, the measure properties, starting with specifications.

Any comments, Richard or Steven, on the specs for the measure?

Richard Madonna: None beyond what I've already said.

Reva Winkler: Yes, OK. The question is, what constitutes counseling?

Steven, anything from you?

Steven Strode: No.

Reva Winkler: OK, anything from anybody in the workgroup? You feel the measure – the specifications are clear, well defined, likely to be implemented consistently from one practitioner to the next, because that's really what we're – what we want to see in terms of reliability.

Again, reliability testing, similar to a previous measure, AAO is presented there, the testing from measure score and data element.

Richard and Steven, your thoughts on the reliability testing.

Richard Madonna: Let me – I'm sorry, let me find my notes here.

I don't believe I had anything on that. I'm sorry.

Reva Winkler: All right.

Richard Madonna: All right, to reliability.

Reva Winkler: OK.

Richard Madonna: Other than what you see in the pre-evaluation comments.

Reva Winkler: OK. Steven, any thoughts from you?

Steven Strode: It was based on a single ophthalmologist that it seemed to be a good effort at reliability and I don't have any big problem with that.

I think the question ...

Reva Winkler: Yes.

Steven Strode: ...was raised earlier, which is very valid and that is, would some people check off, "I have done counseling", and that it might be very perfunctory and other people would do a great job, but is the same checkmark.

And I don't know how we get around that.

Reva Winkler: All right. OK. Thoughts from anybody else from the workgroup on the reliability testing?

OK. All right. So we can move down to validity. And very similar to what we were discussing with the previous measure, face validity testing and then threats to validity, there are no exclusions for this measure, it's not risk adjusted. We do have data, I believe, from the IRIS Registry showing distribution and statistics over that group.

Any comments, Richard or Steven, about the validity of the measure, any concerns?

Richard Madonna: I think it's similar to before we said that it based upon the information that we have the top measurement rating would be moderate, I think (inaudible).

Reva Winkler: Correct. For validity testing, yes.

Richard Madonna: Yes.

Reva Winkler: OK. Yes. Any thoughts from anybody else from the workgroup?

OK. In ...

Steven Strode: On this measure – this is Steve again. On this measure is others in this grouping, there is mentioned that there would be reasons why the physician would say this needs – this particular encounter doesn't need to be scored, or where the patient would say, "I don't want the counseling."

Comments were made, which I think were very good to say, this should be rare and it should be documented as to why either the physician's preference or the patient's preference should exclude this. I don't know how it worked

that into the actual expectations of the measure, but it's good practice and it's good documentation when it's done.

Reva Winkler: Measure developer have any comment and response?

Just looking at the measure specifications, this – they do not specify exclusions at all. So all patients would be counted.

Steven Strode: Yes.

Reva Winkler: OK.

Scott Friedman: Yes, it's hard to document patients doesn't want to hear what you have to say about their condition. I'm not sure how you get it done.

And I've been doing this for 30 years. I not really ever experienced that, very rarely.

Reva Winkler: OK. All right, good.

OK. Any other thoughts on validity, then we can move down to feasibility and use and usability? And I think given this measure is very similar to the last one, the issue should be pretty much the same.

Does anybody in the workgroup have any comments on either of those criteria?

Richard Madonna: I would agree.

Reva Winkler: OK. I just don't want to belabor them when essentially when we've already discussed it.

So, any further comments on this measure before we move onto another, and we're moving onto a different topic and condition?

OK. So, the next measure that we're going to be looking at is measure 88 and this is Diabetic Retinopathy, Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.

This one is from AMA-PCPI, and I know we've got some folks from PCPI on the line. And, this measure is intended for use at the clinician group practice or individual level.

So, our lead discussants for this are Andy and Steven. So, Andy, what do you think about the evidence for this measure?

Andrew Schachat: Sure. So this is a measure of the rate of doing a dilated (entrance) exam and then scoring whether there's diabetic macular edema and scoring the level of retinopathy severity.

I think there's good evidence that diabetic macular edema can be asymptomatic. And if treated earlier, leads to better outcomes. So – oh, and you can't see it really without doing a dilated exam.

And, so I think the data there is pretty good.

The data is a little less good for scoring this retinopathy severity level, because that's one step removed – one more step removed from vision compared to diabetic macular edema. The thing that affects vision or (the scrolly) of proliferative disease, basically, and the retinopathy severity level is a predictor of the speed with which the patient will get proliferative disease so it drives the timing of the next recommendation for a follow-up visit whether it's three months, six months or a year, that kind of thing.

So it's reasonable to assume that finding the retinopathy level and then telling the patient when to come back is going to allow catching proliferative disease sooner, which will allow better outcomes. But it's – there are a couple of assumes in there. So, it's less clearly linked than the macular edema one.

But that's just my general comment on the measure overall.

Reva Winkler: OK. All right. Steven, any thoughts on the evidence for the measure?

Steven Strode: I think that was a great summary.

Reva Winkler: OK. Thoughts from anybody else? All right.

Scott Friedman: Yes, I do. So, Scott Friedman. So, there is data that came out showing that treating patients with anti-VEGF and steroids reduces the level of retinopathy, it actually goes down.

And so – and then there's been some change in indication for medications for treating patients with diabetic retinopathy and there's some new studies that are going to be starting soon. So, I think this will become more important as more data comes out showing that drugs that we treat retinopathy and in fact help prevent flow for changes as Andy suggested and may save vision down the road.

Reva Winkler: Super.

All right. So let's take a look and see how performance is, data was provided from the PQRS program, we don't have the details of the number of participants, but I'm assuming we can extrapolate and as soon as probably similar numbers and high level. Again, thoughts on the opportunity for improvement.

Andrew Schachat: I'd make the same comments that we made about the macular degeneration one, which is that the people who are doing this measure now or the retina specialists and they're going to have higher rates. And the people who aren't doing it clearly have lower rates. And by moving this measure forward, we're going to encourage more people to pay attention to this. So I think this is a very nice opportunity for improvement.

Reva Winkler: OK. Super.

Steven, anything from you?

Steven Strode: No.

Reva Winkler: OK. Anybody else?

All right, then let's move on down to scientific acceptability. And how about the specifications? This measure has both an eMeasure version as well as the registry version presented.

Andrew Schachat: So it's Andy. I don't know if my comments are going to go in this section or not. But instead I have four questions. I don't understand what a composite measure is. It seems to me that there are three things here that you need to win doing a dilated exam noting the presence of – and noting the retinopathy severity level.

So, it's sounds to me like it's a composite measure. I'll just leave you with that. And let's – Reva, do you want to teach us where…

Reva Winkler: Yes. I mean, you know, you're raising a point that sometimes gets a little too fine. But in general composite measure is combining individual measures in such a way that you end up with a single score. But we often see measures like this that have – that it takes multiple things to qualify to get counted in the numerator that are not considered composite measures. But again, we also don't see those individual elements as individual measures.

So, you know, there's a gray area between the two, but this is not a considered a composite measures.

Andrew Schachat: OK, I'll drop that. And my next question is, I think you – the measure is did you this within the last year, I think. And I think that you sort of report this once a year. And I don't know if how it works with when the reports goes in, what time of year it is, and if it counts for this year, last year, or next year. So, I just thought and how the once a year measures work. You don't have a chance to see every patient that year even though you're supposed to report it because patients can come, you know, the months vary and a minute you're saying this right, but I hope you understand the problem I've been worried about.

Reva Winkler: Right, somebody from PCPI want to respond?

Scott Friedman: So, it's Scott Friedman. So, if you didn't see in the calendar year, you obviously aren't going to report on them. If they were seeing – if they were seeing in that year and they have the fulfill the criteria then you have the capability of reporting. Let's say they don't want to have a dilated exam then in there you can just bring him back and have them and for whatever reason bring them back and do another dilated exam. But obviously, if they're

coming back every two years they just – they don't get reported. There's nothing happens for that particular calendar year.

Andrew Schachat: I guess my question was a little bit related when does the static (outruns)? Run on December 31st at midnight every year?

Scott Friedman: Sure. So, basically, I think if – if you reporting it with the registry gets batch and reported once a year, I believe, and Bill can comment on that, or you could do it through other methods and just reported as you see the patients. And then you can get score – you can be scored in periodically. But I mean, I'm reporting back in – when we started reporting I report (treat) individual patient. You know, as I saw the patients. And then with registries, it can – it has to be the – it does it for you on the background and they (came back), and then report all at once. So, the success rate apparently goes up tremendously with registry.

Andrew Schachat: All right, I'm going to drop this in the interest of time. I'm two simpler – but thank you, I have two simpler comments. I think in the list of ICD-9 codes, 362.07 was not listed for diabetic molecular edema. So, I think that was left out under specifications, I think.

And under the specific comments, the verbal comments about diabetic retinopathy severity level. Verbally, they were comments about separating mild, moderate, severe, and very severe. And very severe is one of the key drivers of the rate of getting proliferative disease. But very severe and severe have the same ICD-9 code.

It is known differentiation of that based on coding. So, I just mentioned those. There are little tweaks to work on as this is refined and finalize.

Bill Rich: Yes, Andy, this is Bill Rich. The health policy committee is really looking very carefully on our chronic diseases and there's not enough granularity in the specification that we've submitted new recommendations for ICD-9 or 10 or 11 now, they will actually fill in those blanks varying process.

(Off-mike)

Jamie Jouza: This is Jamie from the AMA-PCPI and I also want to add that within our eMeasure and the value such that we have pertinent to this measure and the electronic implementation of it. There are actually three different terminologies that could be used for diagnosis and when it comes to the value set within the numerator for the level of severity of neuropathy, we used (SNOMED). And very severe is actually captured in the (SNOMED) terminology.

And so, that is – that's another way, it's not – it's an (HITC) in it committee recommended and vote (February). So, it's not anything that's necessarily captured in the claims or registry effect but it's definitely within the electronic and it could be implemented in the registry version but it is – it's not able to be capture within claims.

Reva Winkler: Thanks Jamie. Any other questions or comments on the specifications, Andy or Steven?

Steven Strode: Nope.

Andrew Schachat: Nope.

Reva Winkler: OK. Alrighty. So, let's go down to the reliability testing. And so, we do have information presented for claims from the PQRS claims database, the registry which is via the PQRS (get for) database. But we don't have – and the testing for the eMeasure is done at the data elements, validity testing and it will count for both validity and reliability.

So, any comments about the empiric testing and reliability for the measure, Andy or Steven?

Steven Strode: Seems adequate to me. This is Steve.

Reva Winkler: OK.

Andrew Schachat: I didn't have comments.

Reva Winkler: OK. I just – for the ophthalmologist on the group, you're being measured on this, do you feel they've demonstrated sufficient reliability and the measures that you're comfortable being measured with it?

Andrew Schachat: Well, let me just say that – it's Andy. I think we have pretty good data. The clinicians clinically can't score macular edema very reliably. But people are using OCT more, and more, and more and we'll have a very reliable ways of doing it with the safe $17 test, its better. And as far as the retinopathy severity score, again, that's hard to do clinically (stable). But I wouldn't worry about being scored on the basis of this because it's really the opportunity for improvement here.

The better we do with these things, the better our patients are good to see. So, the measure I think encourages better performance on the ability to do these things and if people are going to get scored on that. We're going to do it a little bit better.

Reva Winkler: OK. All right, comments from anybody else? OK. In terms of validity, we do have face validity for the claims registry version. We do have data element validity testing against the EHR, against the goal standard and you see the percents of agreement for the various aspects, for the measure. This is only tested in a single practice or a single EHR. This was done awhile back. And so, with more experience when EHRs were certainly looking forward seeing additional data where the measures tested more widely in more EHRs but we're not there yet.

So, any questions about the criteria or the information provided on validity testing for this measure? From anybody on the workgroup? OK. How about the threats to validity? The – there was an analysis that a number of times that exclusions were actually used in the reporting events for PQRS via the different mechanism. Any questions or issues about the exclusions and the frequency of use from anybody?

OK. Does this seem to be a reasonable rate of exclusions or exceptions for the measure, for eMeasure?

Andrew Schachat: I thought so. I thought it was fine.

Reva Winkler: OK.

Scott Friedman: Oh yes, I think it is.

Reva Winkler: All right, good. And then it's a process measure so it's not risk adjusted. And again, we've got some data on performance around meaningful differences. So, is there – is this measure going to be able to make comparisons among providers and differentiate good quality from perhaps not so good?

Philip Schneider: You know, this is Phil again, and the registry performance state is very powerful. And so, I would say yes. We've never had the ability if you look PQRS, you know, feedback two years later. This is happening in 68th weeks and it's going (to go down) about two weeks probably within about three months.

So, it's pretty glaring the defects that you can see or almost getting real time performance feedback, you know, with the registry.

Reva Winkler: Cool, sounds great. Any other comments from the workgroup? OK. Again, we've got the criteria of feasibility. And again, this measure is specified for several different data sources, lots of electronic data. We do have a feasibility score card that was provided looking at the data elements and availability in EHR systems.

So, Andy or Steven, any comments or thoughts about feasibility for this measure?

Andrew Schachat: I thought it was quite feasible with the minor tweaks I commented on about some of the codes to look at.

Reva Winkler: Sure. OK, anybody else on the workgroup, thoughts about feasibility? When the measure is in used so it is being used.

All right, usability and use. So, again, this measure is part of PQRS and it's also part of meaningful use and it's also in the IRIS Registry. So, this measure is gaining a lot of experience and will be able to have a better indication of how performance is actually happening and improving overtime.

Any questions about the criteria for usability and use for rating this measure or any questions about the information provided on the measure? Andy, Steven, you're good with this one?

Male: Yes.

Reva Winkler: Anybody else in the workgroup as we finished up this measure. We're going to go to a related measure on diabetic retinopathy, there's probably going to be some repetitive kinds of things.

The next one is measure 089 and this is diabetic retinopathy communication with the physician managing on going diabetes care. Again, it's – from PCPI, percentage of patients 18 years and older with the diagnosis of diabetic retinopathy who have the dilated macular or fundus exam performed with document communication to the physician who manages the on going care of the patient with diabetes regarding the findings to the fundus – the exam, at least once within 12 months. Again, intended at the clinician group or individual level.

So, are discussants this time are Scott and Steven. So, Scott what are your thoughts on evidence for this measure?

Scott Friedman: Sure. So, Scott Friedman again, there's a lots of evidence that controlling blood sugar's health and decrease the rate of complications from diabetes specifically diabetic retinopathy, presumably if you decrease the progressionm, diabetic retinopathy say vision. There's no so – lowering hemoglobin A1c, lowering blood sugars is beneficial to patients with diabetic retinopathy.

And the PCP, they're obviously, the main states are treating for counseling the patients and lowering the diabetic retinopathy – lowering blood sugar level. There's no level one evidence that if it's stock corresponds to PCPs, let's say vision but it goes about saying that if someone is having worsening retinopathy and the – it's get reported to the primary care provider that would be beneficial in stressing that to the patient and in theory having better control.

We interest in and we did study where we took patients and measure the hemoglobin A1c in our offices at a central lab and even local in our office and we counsel the patients on control of blood sugars and the data is accepted but it's not on print yet, so I can't report that.

But I think – this is indirect evidence and this goes without saying in my opinion that counseling can never be harmful and probably beneficial in helping prevent vision loss and patients with diabetes.

Reva Winkler: OK. Scott – Steven, your thoughts given your probably at the other end of the communication?

Steven Strode: Yes. I am and I think that was a great summary. This is an area where I think we do rely on hoping common sense but there's every reason to support this. As a primary care physician and perhaps like it even speak for endocrinologist, the other category of on going providers would be that information about what the particular patients needs to do in terms of complying with the eye care plan would be very helpful to.

So, that the PCP, the endocrinologist can be encouraging the patient to follow up with that.

Reva Winkler: This is Reva. Somebody early conversations around this kind of coordination of care were concerns that, you know, that communication between providers just didn't happened very easily or readily, or confirmation that information had actually transferred from one to the other and back again. What's – from your various perspectives, you know, what's the status of data out there?

Bill Rich: Reva, this is Bill, I'll jump in first as a private practitioner who's actually thought on this large failing practice residency in mentored folks for a long time. Even with the H.R.s, there is so many problems with interoperability. I actually type out the reports of the patients report that I'm sending the primary care doctor and I faxed it.

And I think basically if you're not in an integrated system that's what a lot of people with private practice are doing, or they're sending letters and now before Scott who's in private practice. Andy is integrated system. But this is

really a key factor after the diabetes complication controlled viral in '92, we've grammatically decreased the population blindness in this country. I think what (Perez) says it's close to 70 percent.

So, the little stuff is the big stuff and we've strongly feels a profession at this communication is key. Scott or Andy, what is your – how are you communicating to the primary care docs? But for me, I'm faxing the thing out of the EHR, I can't send it.

Reva Winkler: OK.

(Ephraim Nkosi): Sure, basically – (Ephraim) again. I have electronic health records letters are generated that are easily returnable. They're short and sweet and I just send – I get a referral predominantly from general ophthalmologist and optometrist, I send a copy back to them. I send a letter to them and I send a copy to their primary care provider and/or their endocrinologist or whoever. The patient prefers gets the letter. I don't know for sure that the patients that the docs are actually reading them. But you hope they are, certainly they are available. I also document carefully in my letters that I've sent out to my referrals and/or the primary care provider, the disposition. They're going to get a procedure done, a surgery, a comeback in one month to six months or a year.

So, that's clearly outlined in my letter again, which is a short and sweet, less is more sometimes. And this makes sense to me that this is – it can hurt and it can only help in helping the patients control the retinopathy better.

Rich Bill: I think what Reva is concern is how are you getting that information to coordinate care? Are you faxing them, are you mailing it even though…

(Ephraim Nkosi): Oh sure. So, in my (clicker) instance some – most of docs that goes through the mail. Some of my – some docs prefer to have it send electronically which I do some preferred added fact. We typically clear all referrals and/or the primary care providers and they say how do you preferentially want to have it done and we have a spreadsheet, and we'll send it whoever they want, if they want to send it off three ways better, most people don't.

Andrew Schachat: This is Andy. As Phil mentioned, I mean integrated system and we have a wonderful electronic records and I copy the primary doctor in like two seconds, the letter. And when it's an upside primary doctor we try methodically to collect that information from the patients so we have that outside doctor in and they have a choice of electronic access, we're getting it by fax or mail.

And then for patients who say they don't have a doctor and they can't remember who the doctor is or whatever. I just printed it out and hand it to the patients and say please give it to your doctor when you see them next time.

And I am shock, how of many of the outside doctors respond to me with thank you. So, and they saw it, and they seemed to appreciate it. So, I think we can do that. My concerns or whether this will really enhanced outcomes and I'm not going to be the one to criticize or sink this.

So, Reva if you scroll to where the comments are and where it says, I don't think this measure works. I think just before the in-person meeting, the people will just read that and if you people agree with me, fine, and if I'm the only one, I'll keep my mouth shut.

Reva Winkler: OK. Everybody is welcome to offer your thoughts. I think, you know, this is has been an area of on going conversation in terms of how effective care coordination is and I think in certain circumstances as Andy mentioned, the integrated systems probably have a real advantage because their communications are pretty automated now.

But again, the fact that – people are really having to make efforts to be sure that the communications happening more in the – with external folks. I guess, one of the comments you made that does make – give me pause a little bit in concern is the fact is you're not sure if the PCP or endocrinologist has read it or appreciates it, or the fact that Andy was sort of surprise to hear them saying thank you.

So, I'm kind of getting a sense that may be there is still a lot of room out there to facilitate these communications and coordinate care a little bit better. And I don't know to what degree of measure really kind of address that or whether

any measure truly can. But I do think it's one of the concerns people have about a proper inappropriate care coordination.

Steven Strode: This is Steven Strode. In the studies that were mentions dating back a couple of decades for some. It really showed that there was pretty poor communication between – in this case, the on going diabetes care provider although the studies weren't specific to diabetes and the eye specialist.

So, I agree with you Reva that I think that we can assume that things maybe get a whole lot better. I guess, my point to support a measure of a document. The exchange of information about the eye exam is that if we don't have communication, we'll never get to coordinate care. The communication has to be the first step.

Andrew Schachat: I guess I would just comment that I think coordinate care is critically important and it enhances outcomes. But I would just try and have a measure that says, is there a coordinate care somehow. I just – this is – the assumption that sending a letter is going to improve outcome is a big one for me. Sending a letter is good because it coordinates care but as many steps down the road to see if it's going to improve outcomes and I think that family doctors who don't get a letter or they'll be trying to optimize diabetes management anyway.

I mean, do you not try and control hemoglobin A1c, and blood pressure, and lipids? You get letters or if you don't get letters?

Steven Strode: Sure. But I think we might all agree is regardless whether in primary care or care of the odd that it can be very useful ammunition to try to motivate a person to say, "Oh my goodness, look what your eye doctors says." And here is something that we can do about it both in terms of improving your overall diabetes management. And you're getting back for the procedures that need to be done on your eye.

Andrew Schachat: I guess that's…

Steven Strode: It would be good if at some point there was a quality measure on the PCPs and the endocrinologist that would say if you received the (start) of

communication from the ophthalmologist, did you do something with it? But that's beyond I guess the scope of biggest measures.

Reva Winkler: OK. Any other comments before we move on to the specifications? All right, so, thoughts from the workgroup on the specifications for this measure?

OK. I guess one question I would ask you all about is the exclusions for medical reasons and patients reasons. I guess I'm having – can someone explain to me what an example of those might be why you wouldn't communicate with their primary care doctor?

Scott Friedman: As Andy suggested the, unfortunately, a lot of our patients don't know who their primary care provider is. And (theory), we're not sure how they get their drug. And it's amazing (one) here. So, obviously, as Andy suggested it's a great things for what he does and maybe I should change my practice, should give him a letter to say, hand this to your person who takes care of your diabetes when you see them. But that would be one obvious example of why you can't send a letter someone because you don't know who they are.

Reva Winkler: All right.

Steven Strode: This Steven. As a PCP, I thought that's probably going to be the vast majority of reasons to exclude would be the patients…

Scott Friedman: Or the patients – for some reason doesn't want you to send a letter, and that happens.

Steven Strode: Yes.

Scott Friedman: Maybe you don't like their doctor, who knows. Do not send a letter to my doctor.

Reva Winkler: OK.

Peter Robinson: This is Peter from the academy again. So, just sort of comment on the medical reason. So, I think that was added to prevent physicians being penalized if some reason the patient couldn't be dilated on that exam date. And for whatever reasons and (approximately) to drive (inaudible), they didn't

want to be evaluated that day, so it's just added, so you know, and providers wouldn't be penalized and I say responses that it will enable this obviously, communicate if they couldn't (call mix on to this place).

Reva Winkler: OK, any other comments on the specifications from the workgroup members? OK. Again, we've got both the claims registry version and an eMeasure. So, you're going to find that the information is similar from the previous measure, the reliability testing was done is the claims and registry and then the data and validity and the eMeasure. Any thoughts from Scott or Steven on the results of the reliability testing or the validity testing?

Peter Robinson: I think they were similar to the previous measure and I don't think I require any further discussion.

Reva Winkler: Anything along we talked a little bit about exclusions, meaningful differences, variations, anything there you want to comment on?

Male: No.

Reva Winkler: OK.

Male: No.

Reva Winkler: And I think the feasibility and usability and use are pretty much the same as the prior measure, is there anything you want to add or we just sort of apply the same comments for this measure as well, a lot of duplication?

Andy Schachat: Yes, I think this would be a very easy measure of score especially because there's a CPG code now that says I sent a report.

Reva Winkler: OK. All right. So, any other – less comments on this measure before we move on to our final measure?

OK, so the last measure we're going to talk about is measure 2721 Amblyopia Screening in Children. Now, I need to brief you a little bit about these measures that are new eMeasures that NQF is encouraging measure – eMeasure development and used but eMeasures do have a lot of challenges in

their development and getting them tested and widespread fashion is challenging.

And so, last year NQF began a pilot program that is now essentially been adapted as a way of NQF evaluating new eMeasures that have not been fully tested in multiple EHRs so that we have a lot of robust information about them. But do measure something that's important in meaningful and evidence-based on where there is a quality (problem), women and opportunity for improvement. And the basic information about the measure, the HQMS specifications for the eMeasure. The measure logic has been look and evaluated, the value sets are part of the – the authority center – excuse me – at the LMN. And they've done – pardon me – they've done a feasibility assessment of the data elements of the new eMeasure.

And so, there's not much to say in usability and use because as new measures they are unlikely to be used and it's this recommendation for, you know, being evaluated for approval for eMeasure trial use. It's not the same as endorsement but we really want to see what you as a committee think about the importance to measure and report this new eMeasure.

And some of the issues that it will (rise) and whether you'd recommend that this measure be approve for trial use so that we can get more data. So, it's in a somewhat different bucket if you will. This measure isn't for full NQF endorsement but it is for our new program around granting approval for trial use.

So, is there any question about that?

Andrew Schachat: There is. I'm so not clear on what measure is compared to the others. The others I've (struck) wide on electronic data and stuff. So, I'm not clear whether an eMeasures is supposed to what the other ones were.

Reva Winkler: Right. Well, the other one are existing measures and have some history and track record behind them. Those measures also had non-eMeasure or more traditional measure specifications. The eMeasures actually are something that if sort of come along and because the part of…

Andrew Schachat: Tell me something that was in the previous ones that was not a part of an eMeasure.

Reva Winkler: The claims or registry specifications…

Andrew Schachat: I thought that…

Reva Winkler: … for used data.

Andrew Schachat: … to me that's eMeasures.

Reva Winkler: Not necessarily. Some registries can accept data directly from EHRs but not necessarily it can be submitted to them…

(Crosstalk)

Andrew Schachat: We can talk about getting data automatically add of an EHR that's not a claim or diagnosis?

Reva Winkler: If it's done using the HQMS specifications which are the standard.

Andrew Schachat: OK. Well, then there are a lot of EHRs that are not going to let outside groups in and you're not going to be able to get electronic information.

Reva Winkler: Right. Well, I think these are some of the challenges as we're seeing greater use of eMeasures but trying to get the appropriate testing data is challenging because I'm sure are developers can share with you.

So, essentially what we want to look at for this measure is the criteria around evidence and opportunity for improvement will share with you the result of our internal eMeasure technical review, and then I'm sure the developers can – it can tell you want their plans are for the measure going forward so, why don't we start there.

So, Andy, you and Scott are the discussants for this measure and then measure is titled Amblyopia Screening and Referral in Children. This measure is brought from CMS. Their measure developer contractors Booz Allen and I think we got folks from them on the line.

This is the percentage of children who were screened for the presence of the amblyopia at least once by their 6th birthday and it's necessary we're referred appropriately. So, as I said, this measure is specified as an eMeasure only using the appropriate HQMS format.

So, in terms of evidence, Andy and Scott, for this measure, what are your thoughts about the evidence for measuring this process of care?

Scott Friedman: I'll go first. I had a question with the design in this measure. So, basically kids are being screened for decreased vision and not amblyopia. So, I think the majority of kids that are going to fail a screen exam are going to have a refractive there and not have amblyopia.

No, I'm not saying that referral for (children) shouldn't be screened, although, I'm not certain, how much evidence there is a benefit for that. But it – if one needs a differentiate people with decreased vision an amblyopia.

So, in the new measure you're going to have kids with amblyopia. We couldn't have probably the majority kids are not going to have amblyopia and just have a refractive or myopia, they're going to be corrective with glasses so that wasn't clear to me. If someone who develop the measure could discuss that that would be helpful.

Reva Winkler: Do we have our measure developers on the phone.

Dan Roman: Hi there, this is Dan Roman with NCQA. So, we are the measure specification lead under the Booz Allen contract. We developed – and we work on this measure for CMS and the office of National Coordinator for Health I.T. The basis for this measure is the USPSTF recommendation that it focuses on amblyopia screening only is what the recommendation that we based the measure on.

So, we're not – we weren't looking at those other types of conditions or issues that you're referencing. I guess my question back would be if you're saying that the way the measure is set up that what we have in there for screening is not going to detect amblyopia…

Scott Friedman: And that's correct. Well, who – it depends and let's say similar within expertise in amblyopia screening them, you're not going to detect amblyopia. You're going to detect kids, basically, you're going to measure vision in kids and they're going to – and normal 20/20, and they're going to have decreased vision and one or both of their eyes. They're going to be seen by an eye care provider and the majority of those kids are going to have a refractive error and get glasses and be correctible to 20/20 have – are be correctible to normal vision with glasses.

Andrew Schachat: Yes. So, it might be sensitive but it's not going to be specific.

Scott Friedman: Exactly, yes.

Dan Roman: So, would you say though then to make our measure better or more specific is it, is it just the wording we chose. So, if we just said vision screening or, you know, I'm not – I'm just trying to figure out how we can make it so that the measure is says what it's doing and it's actually, you know, it's looking for the right things that are actually going to found in primary care.

So, if saying amblyopia is incorrect. So, again, we're modeling it also what we look at the with the USPSTF recommendation and then were work with the American Academy of Pediatrics and one of their experts to kind of – we'll have the wording.

And again, this measure initially was a vision screening measure that, you know, before we touch it, before within eMeasure, there was an NQF endorsed version of this measure. The AAP was the (steward). And so, we kind of work off of that measure to get to here and so, you know, I don't think anybody is tied to the exact wording that we have here.

So, if it's confusing and it's not appropriate we're happy to modified so that it's makes more sense, so if I guess my question is, you know, would it make more sense for us to say just a vision screening and then include, you know, the visual acuity study that we have an enumerator as kind of what it makes a numerator compliant.

Scott Friedman. What. I mean basically children who are screened to detect the presence of decreased vision between it turn 6th birthday and if necessary refer to an eye care specialist for the detection of amblyopia.

Dan Roman: That makes more sense. OK.

Scott Friedman: Or – if the – if you want to look at amblyopia as that. That's it. I mean or you could just say if you want to look at screening kids with decrease vision and just correct them which maybe beneficial. But for what your purpose it's not stated correctly.

Dan Roman: Got it, understood. And I think I'm getting it the purpose of this measure is to increase screening for problems in primary care. So, you know, we are looking to have this done and so what I'm hearing is that, you know, the primary care setting, they're not necessarily going to say, "This is amblyopia, this is not." But they are going to detect that there is decrease vision or some type of vision problem and then that case they refer them on.

Scott Friedman: Exactly.

Dan Roman: OK.

Scott Friedman: Perfect.

Dan Roman: Very helpful. Thank you. So, I mean, you know, I don't know what the correct protocol is but as far as the measure develop does not being the measure developer are perspective. We are happy to adjust that wording for this measure.

Reva Winkler: Yes.

Andrew Schachat: Yes.

Reva Winkler: This is Reva, we're happy to work with you and…

Dan Roman: OK.

Reva Winkler: … you know, as we go through the process if you want to change it and so that it's more understandable for everybody, that's fine.

Dan Roman: Great.

Bill Rich: Yes, just a great comment to the measure developer, Reva, this is Bill Rich. There's a robust literature and agreement between American Academy of Pediatric Ophthalmology (into) business and the – and they have an entire section as AAP.

So, I think that this could be resolve with the couple of telephone calls but doesn't look like the word against – it requires a little bit more wording and we'll be glad to help a little bit of exactly develop and they'll measure IRIS Registry but I understand this one is for primary care but there's robust in literature in agreement between three different organization so and (help) to do this and maybe if you would like to e-mail myself I could try to coordinate that between you, the Pedipods (inaudible) in your academy but this robust literature in this and how to approach this.

Dan Roman: Great. Sure, that would be great. Thank you.

Reva Winkler: Again, from NQF perspective because this is, you know, a measure for trial use and isn't really being evaluated for full endorsement we're happy to have you make appropriate changes as needed and we'll see where we are at the time of the in-person meeting.

So, any other thoughts besides that rather big one in terms of the evidence for the measure? Scott and Andy, any other thoughts on opportunity for improvement?

Andrew Schachat: I have some big picture comment.

Reva Winkler: OK, good.

Andrew Schachat: So, I think it's a given that treating amblyopia helps vision. I think it's given plenty of kids are undetected and array symptomatic, the parents have no idea. So, kind of screening is necessary. It's clear that screening can detect it. And

it's a little unclear that if someone is screened then it's linked to better outcomes. Later, we just assumed that they get or probably referred inappropriately treated but it's a reasonable start.

I would just point out I think it's already become clear. There are a lots of different screening strategies. So, there are many ways to screen. It's not obvious if it's one that's any better.

Once you detected, there are a lot of ways to treat it and there's been lots of research on better ways of treating and what strategy he used but there are different recipes. So, I think this is going to be lots of variation but this training in detection is good. State law is vary, so there are different states where different screening systems are required by law, and a lot of the screening and Bill knows much better than I do is done is schools so that outside health care system.

So, I just wonder if this is going to duplicate some screening that's already out there is going to get in the way of screening that's out there and we'll doctor score vary state by state because of screening laws, control the behavior. And so, I just have lots of questions about that.

So, I really support screening for amblyopia. I just have questions about this measure.

Dan Roman: So, this is Dan again, I think, you know, I think there's all great question, I think there's a big potential for some duplication for all the reasons you just said, this measure as Reva said, it's an eMeasure, we developed it under contract or sorry, I shouldn't say we developed it, because like I said, it was based on a previously existing NQF endorsed measure. But this is an eMeasure with developed for programs that the center for Medicare and Medicaid runs. So the EHR incentive program in one, potentially if you, it would be used in a Medicaid chip programs.

Intravenous is the main program the EHR incentive program though that is for physician level or hospital level accountability. It's a reporting program so they know there is no incentive other than to report your data. They're not created on performance but the level of accountability is the physician level.

And so, if not clear year for us anyway, how that's going – like how we would – how we would include school assessment centered on a school or any type of screening that's done in the school. I think that's kind of a bigger programmatic question than what we can answer today, I think it's a valid question the state by state also, another valid point.

I think for us, the contract you who should develop this measure. It's a really tough one to answer and I think that we've kind of – we would need more input from those who run the program is potentially if this measure would be implemented in. So, that would be CMS folks or the office of National Coordinator.

We have explored, yes, we are trying to explore some additional methods of testing this measure and I think that that something that, you know, with getting the measure out in the public more and get it used more if we potentially can find out more about it but right now we just don't have a great answer for you.

Reva Winkler: OK, thoughts from anybody else on the workgroup on for evidence or opportunity for improvement? OK. The other thing will focus in on are the specifications. So, I want to be sure that workgroup members are able to access the measure specifications. There is a file in your documents that has all of the HQMS state, eMeasures standards format for eMeasures, and one of the documents is the human readable specifications and calculation algorithm and I just want to be sure everybody can – knows where to find that.

It is in your document sets on SharePoint with the rest of the information. It is on a separate file from your work sheet. And so, internally NQF is taking a look and work with measure developer and done our eMeasure technical review and you see the results of percentage in the preliminary analysis worksheet that there is eMeasure HQMS standards specifications, it does capture the data elements and logic needed for automated calculation.

Some of the value sets are not yet present in LMN and we'll need to be submitted the feasibility analysis was done. But again, as the developers have indicated they're really having a chance to really test this measure out in the

real world. But I think looking for an assessment of whether this measure. Measure something evidence space and important and at least to the specifications of reflect that type of measures so that it could be further tested in the real world and get some hard data on it.

So, any thoughts on Andy or Scott on the measure specifications as drafted by them?

Andrew Schachat: No.

Scott Friedman: No.

Reva Winkler: OK. All right, I mean I think the big picture questions you, you offered Andy and then they comment you all already offered I think are really good start and feedback to the measure developers and will see where we're at the in-person meeting in terms of this measure and where they want to go with it. So, we'll be in touch with the developers as we get ready for the in-person meeting.

So, anybody have any other comments from this measure?

OK. Well, we've had a chance to go over all five of the measures from this workgroup and a chance to review the criteria and the evaluation. In preparation for the in-person meeting, in June what we're going to do is sort of a same thing we've done today but with the entire committee.

We will be asking the lead discussants to present their initial thoughts and those of the workgroup from the preliminary comments in your discussions to your fellow members of the committee to begin the discussion around each of the criteria for measure.

So, we will be going through in sequence each of the criteria and allow the entire committee to ask any questions or join them and discussion. The lead discussants and members of the workgroups are going to be the folks that spent the most time looking at these measures and we'll be able to start the conversation and help facilitate that. For each criteria the committee will be to vote on their rating.

And so, we will be asking for a formal vote among the members on how you will rate the different criteria evidence opportunity for improvement reliability, validity, et cetera, et cetera, as well as finally a recommendation for endorsement and since all of the measure except for the last measure we talk about are previously endorse. They are from maintenance reviews so it's a recommendation for continued endorsement.

Depending on where we're at with the amblyopia measure that would really be a recommendation for NQF granting approval for trial use and we'll just see where we're at with the measure by the time where at the in-person meeting.

So, that's how we're planning for the in-person meeting evaluation to go to anybody on the workgroup do you have any questions about where we go from here and the next steps from the evaluation process?

OK, yes?

Andrew Schachat: This is Andy. Is work going to go on for us between now and the meeting and we're going to be seeing lots of new versions and new data or is it more just for us to go over the information that we've had and understand it better.

Reva Winkler: Yes. You pretty much have the information that we are – that we have available for your evaluation so it's more a matter of just using this to prepare yourself for the in-person meeting.

Andrew Schachat: Thank you.

Reva Winkler: Sure. So, are there any other questions around the whole evaluation process from the workgroup members and what's going to be happening on the next couple of weeks? As I mentioned you were the third of four workgroups so your colleagues on the committee are going to the same process in other workgroup meetings and they will be bringing their discussion and thoughts to the large group for in-person meeting.

So, any other questions from anybody on the workgroup before go to public comment? OK, as with every conference call as part of our process we make

sure if anybody who was listening in on a call in the audience wants to make a comment.

So, operator would you see if there's any public comment, please.

Operator: Yes ma'am. At this time, if you would like to make a comment and please press star then the number one.

There are no public comments at this time.

Reva Winkler: OK, thanks so much. Just to reminders to the committee, during the in-person meeting we will be taking a session to ask for public comment either for the audience folks that might be in the room or who have called in. This is a public meeting and so anyone who's interested is welcome to call in and offer comments and feedback to the committee. So, just be aware of that.

So, if there are no – yes?

Vy Luong: Reva, this is Vy. I just want us to make a note, if you have not registered for the in-person meeting yet, please do so. And if you have any questions and regard to the logistics for the in-person meeting, please e-mail me or the project inbox and I will help you with that. Thanks.

Reva Winkler: Great. Any last minute questions before we finish today from anybody? OK. Well, again, I thank you all very much for a really good discussions. I think you've had an opportunity to really look at the information around the criteria and the measures in preparation for the in-person meeting and I do thank you for the work and the time that I know you've put into it already. And I really look forward to meeting you all in-person and seeing you in June at the in-person meeting in Washington.

So, with that, for me and my team members, we thank you very much and you got a few extra minutes in your day. So, thanks a lot. We'll talk to you soon.

Male: Thank you very much.

Male: Thank you.

Male: Thank you.

Female: Thank you.

Female: Thank you.

END