NATIONAL QUALITY FORUM

Moderator: EENT Group
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OPERATOR: This is Conference #: 83537338.

Welcome everyone. The webcast is about to begin. Please note today's call is being recorded, please stand by.

Vy Luong: Hi everyone, this is Vy Luong and I want to welcome you to the EENT Standing Committee Workgroup Call Number 4. So, this is the last of the workgroup call. And I'm very excited to have everyone on board.

I am the project manager on the EENT project. Along with me, I have Reva Winkler; the Senior Director, Shaconna Gorham, the Senior Project Manager as well as Kaitlynn Ector-Robinson, who is the new project analyst that will be joining us moving forward.

So, at this point in time, I just want to make sure that we have all the developers on the line. So, we have people from the American Academy of Otolaryngology.

Male: Yes.

Vy Luong: Yes, so, OK, great, and then AMA-PCPI?

Female: Yes, we're on the line.

Vy Luong: Thank you. And now I like to introduce the workgroup members that will member joining us today. Kathleen Yaremchuk?

Kathleen Yaremchuk: Hi.

(Crosstalk)

Vy Luong: Hi. Is Michael Stewart on the line by any chance? He's calling in, so he will be on the line shortly. Seth Goldberg?

Seth Goldberg: Hello.

Vy Luong: Hello, and then Todd Rambasek?

Todd Rambasek: I'm here.

Vy Luong: OK, great. Thank you so much everyone. And now I'll hand it over to Reva, who will begin the discussion.

Reva Winkler: Thanks for joining us everybody. Today, I'll purpose for this call is really to allow the workgroup members an opportunity to have some preliminary discussion about the measures that you will be evaluating at the in-person meeting in two weeks actually.

Because many of you are new to the NQF process, this is an opportunity to ask any questions about the measure evaluation criteria, be sure that you understand what the expectations are. And we will be going through each of the measures and through each of the criteria.

The measure developers are on the line. They are available to answer any of your questions or clarify anything. And so, this is just a chance to share information to be share that we are all working with the best information we have in doing this evaluations.

So, is Michael Stewart joins us yet?

Female: He has not join, Reva. However, Vy is talking to his assistant, so he should be joining.

Reva Winkler: OK, all righty. Well, you know, Michael has got – is a lead discussant on a couple of measures but, why don't we go ahead and just start with the first one.

The first measure is measure 653. This is acute Acute Otitis Externa Topical Therapy. It's a percentage of patient's age two years and older with a diagnosis of AOE who are prescribed topical preparations.

So, I think on the webcast we're showing the measures worksheets for some of the information is there but I think all of the workgroup members have this – from your SharePoint sites so whichever sites works for you, it's fine.

So, Kathleen, you are the discussant with Michael. So, we just keep hoping Michael will join us momentarily.

Kathleen Yaremchuk: OK.

Reva Winkler: So, maybe we can have you start off and your thoughts about on the first criteria which is important to measuring report which consist of one, the evidence, since this is a process measure. We're looking for the relationship of the process to the outcome measure or to the outcome for patients. And the other sub-criteria for importance will be the opportunity for improvement.

So, why don't you share your thoughts on evidence for this measure?

Kathleen Yaremchuk: OK. So, I think the evidence is good. There was a recent guideline 2014 from the American Academy looking at this. So, there's a systematic review that was performed, you know, as far as evidence-based if we graded A, B, C. It is a grade B, I think that as far as I said the evidence I think it's very good to be able to look at this

And it's basically for otitis externa using topical systemic therapy. And the issue being systemic antibiotics overuse, antibiotic resistance and the issues that go along with that versus using a topical agent which has better performance in terms of treating these conditions and less concern regarding over utilization, antibiotic resistance and that kind of thing.

Reva Winkler: Great. So, has Michael joined us yet?

(Crosstalk)

Reva Winkler: OK, we keep hoping.

All right. So, any questions or thoughts from any of the workgroup members on the evidence for this measure?

Male: No, and it's exactly the same as for the systemic antibiotics.

Reva Winkler: Right, yes. So, I just want to be sure everybody is OK with the understanding the criteria and what we're looking for the evidence?

Male: Yes.

Reva Winkler: OK. All right, well, we'll just hope Michael joins us at some point.

And so then we go down to the opportunity for improvement or performance gap as well as any disinformation around disparity. This is a measure but it is reported in the PQRS program and we do have aggregate results of the participants in PQRS over a four-year period.

Thoughts, Kathleen or others about the opportunity for improvement for this measure?

Kathleen Yaremchuk: I mean, when I look at it, it appeared and I look at the data and says, it's like a gap of 16 percent or so in terms of not being compliant with it converse – and so the question is the 16 percent high enough for us to go after. And there is a certain time when you have enough and maybe it's 90 percent or 95 percent but I don't know if NQF is a guidelines for that or if that's based on the severity of the process or have not doing it, you know, continuous.

Reva Winkler: Yes. NQF does not have specific guidelines, I think that's where you're particular expertise can help us understand and interpret this even more specifically because I guess the question would be from your perspective as a clinician, do you think it's reasonable that only 84 percent of people are, you

know, of clinicians who are voluntarily reporting their data to meet this measure.

Can you explain – you know, can you think of reasons why that there is still a performance gap?

Kathleen Yaremchuk: Yes, and I think it's probably education. I don't – and so I think it's possible that is some specialties like pediatrics and other areas or family practice, they may still be doing this but it maybe ENT as well.

The other – so there is two things that I look at, this one is 14 percent significant enough but then the flipside of that or 16 percent is the issues that you have 2.4 million visits. So, it's a very common disease. So, if you have 16 percent that are aligned with this, then in fact that's a huge number.

Reva Winkler: Thoughts from anybody else from the workgroup? We don't have any information about disparities. Is there anybody in the workgroup have any thoughts about disparities for this type of condition?

Kathleen Yaremchuk: I thought about it. And it's hard to see, I mean sometimes you think, you know, it would be universal, but then at times it doesn't. And so then the question is – and I thought for PQRS there were very, even though, it was been four years, there was a very low number of people that were reporting on this.

Reva Winkler: Right. You know, we didn't get the data with this specific numbers but …

Kathleen Yaremchuk: It was just – I thought it was like maybe 4,000 people had reported on PQRS, and if somebody is on the line that can clarify, how many people reported this measure. That would be helpful.

And the other question is whether or not you can, is there a way to find out whether or not there is disparity by finding out ZIP code analysis or something like that to see where that 16 percent that still isn't reporting is coming from.

Reva Winkler: I don't think PQRS was doing that kind of level of analysis at this point. But is the developer on the line? Do you have your data from PQRS in terms of the number of clinicians that reported?

Sam Tierney: Yes. Hi Reva, this is Sam Tierney with AMA-PCPI, we're working and consultation with (AAO HMS) on these submissions and the support to the support process. And we're pulling up that information right now.

Reva Winkler: OK, so just maybe helpful for contact.

Sam Tierney: Yes, I don't know if you want to go on and we can comeback to it. It will take some minutes.

Reva Winkler: Sure.

(Rich Rosenthal): Excuse me. This is (Rich Rosenthal), (AAO HMS) as well, if I could just make a comment about gaps in care. Even though 84 percent seemed to be doing it, acute otitis externa is an extraordinary painful condition which can really be incapacitating. And the topical therapy is the key to relieving the pain. So, I do think that goes into the equation and that apparently, even under the best circumstances with self-reporting, 16 percent of patients or probably suffering a lot of pain that's avoidable.

Reva Winkler: Is there thoughts or comments from the workgroup members before we move under the next criteria? Is Michael joined us at all?

Vy Luong: Michael …

(Crosstalk)

Reva Winkler: OK, still no word from him. OK.

So, as we go down to the next criteria which is scientific acceptability. The first is part is reliability. And reliability, we look at two aspects, we look at the specifications. We look at how well there are defined if there are appropriate codes being used and whether particularly with ICD-9 whether we have the ICD-10 codes as well.

We also going to look at the – calculation algorithm to determine how the measure is actually calculated. So, we're looking at the specifications for how this measure is actually – the measure results are actually created.

So, any thoughts Kathleen on the specification or any comments?

Kathleen Yaremchuk: No, I think they're very good. It can be captured electronically in terms of the antibiotic that's chosen as well as the diagnostic codes. So, I think this is a good measure from – to be able to do administrative way.

Reva Winkler: How would you handle the exceptions or exclusions that are kind of broad category of medical reasons or …

Kathleen Yaremchuk: That was the only thing that I had concerns about in terms of if there could be some kind of dropdown category for that. You know, there are often times, you know, patients – Americans – when I say patients, it's going to be parental preference kind of thing.

I want a system antibiotic. I want a pill or the drops kind of thing. And that's the one thing I think for the measures that I look at. The idea of exclusionary criteria were not – I'm going to say helpful or as you said too broad.

Reva Winkler: Thoughts from the other workgroup members?

Michael Stewart: I'm sorry. It's Mickey Stewart, I'm just – we're having trouble with his line but I'm here. Where are we?

Reva Winkler: We're looking at measure – the first Measure 653, Otitis Externa, and we're looking at the specifications.

Michael Stewart: OK.

Reva Winkler: So great, I'm glad you could join us.

Kathleen Yaremchuk: So, Mickey, this is Kathy. I had gone through and we had kind of gone through the scientific data or the validity of the measure. And we were talking about the exclusion criteria. And the exclusion criteria is we're kind of broad and my only comment was – would there be a way to stratify those a

little bit more allergic to inability to use or something else. And I don't know if you had any thoughts about that.

Michael Stewart: That's a good idea. Unable to use topical and, you know, potentially some other comorbidity …

Kathleen Yaremchuk: Some other regions.

Michael Stewart: … something like that.

Kathleen Yaremchuk: Right.

Michael Stewart: Correct. Presence of cellulitis, you know, so like a complicating factor, comorbidity in the patient and then maybe other or something.

Kathleen Yaremchuk: Yes.

Female: Yes.

Kathleen Yaremchuk: I was thinking, parental preference often times in pediatric conditions, you know, much like immunization. It's not so much the patient making the decision but the parental preference. And I know that pediatrician is often struggle with, you know, I need an antibiotic from my kid to sleep or I need an antibiotic for something and the drops, you know, versus the systemic, maybe on of those.

But it's also good in terms of feedback for us to know that.

Reva Winkler: OK. All right, the other …

Michael Stewart: The patient education issue.

Kathleen Yaremchuk: Yes.

Michael Stewart: And that resistance needs to be overcome if we're going to improve our processes.

Kathleen Yaremchuk: I don't disagree.

Reva Winkler: OK. So, the other aspect to reliability is empiric testing and it is – for this particular measure they do – the developers do present – and reliability testing, some two groups of participants at the PQRS program. The individuals and then group, choosing the group reporting option.

So, measure score reliability was evaluated with the results of presented to you, the average of reliability for the average number of quality reporting events was 0.95 which is quite high actually. And for the group that was in the 0.91 range.

Any questions about what that kind of testing means and how it reflects reliability of the measure results? Any comments from the workgroup members?

Michael Stewart: Yes. This is unfamiliar to me. I wouldn't mind having an explanation.

Reva Winkler: Sure. When you're evaluating the empirical reliability of a measure, you can look at either the reliability of the data elements which can be done for – like in different ways but a common one might be interrater reliability of two different abstractors.

But the other is the reliability of the measure score. And the questions, how reliable is that score. And the common analysis as done here and most of the measures we see is a signal to noise analysis that looks at the data from a variety of participants and is able to statistically determine how much of the actual measure result is through signal performance signal versus noise.

And the results are scale from zero to one, and the higher – closer to one is the closer to 100 percent signal compared to the amount of noise. So, 0.95 and a 0.91 shows about 90 percent of the signal in the measure rebuild is from performance rather than noise in the calculation. Does that help?

Michael Stewart: Yes. So, that's – another aspect here and that is the reliability of the examiners to make a correct diagnosis.

Reva Winkler: Right.

Michael Stewart: Patient coming in with the complaint of ear pain may not have otitis externa but maybe incorrectly diagnosed as having that.

Reva Winkler: Yes. I guess what I would respond is though provider is diagnosis it with otitis externa, however, they're entering that diagnosis as of ICD-9 code and they are choosing to treat it with either a systemic or a topical. So, whether the diagnosis is correct or not, the process for treating that diagnosis is being chosen.

Michael Stewart: Right.

Reva Winkler: Yes. I think this is a question that gets raised commonly and a lot of different committees and the question is how can we measure the accuracy of diagnosis? Which these measures typically don't do and but it is a very reasonable question ask, but at this point, we don't have a real good tool for doing that.

All right, any other thoughts on reliability? We can go down to validity. Validity is based on a couple of different criteria, certainly, whether the measure actually reflect the evidence that we've discussed if we have a measure that talks about something else then our evaluation of the evidence wasn't particularly helpful.

The empiric validity testing is something we certainly look to see out. It's harder to empiric validity testing on measures. We do allow for face validity – systematic assessment of face validity for the measures. However, for validity, if that's the only empiric testing that was performed the highest rating that you should be given the measure is a moderate rating that really doesn't qualify for a high rating.

And that's what we see in this particular case, and the simple fact is that most committees are also doing their own sort of assessment of face validity of the measure. You know, does this measure seem to provide good measure of quality of care.

So, the other thing to look at though and to consider a potential threats to validity, and the threats to validity include a couple of things, including your discussion on exclusion.

And here are some data that may help a little bit further on that conversation about the frequency of use of those exclusions from the PQRS data, so that they tell you that the – the total number of exceptions, the average number per physician and the overall exception rate at 5.7 percent. So, though the range is fairly significant, for individuals, and you see it in the group with – again, a small number of physicians but nonetheless and as the overall exception rate was 11 percent.

So, we are seeing the used of those exceptions. But, the way the measure constructed we don't aren't able to stratified those or figure out, you know, the actual reasons that we're chosen.

Any thoughts on your conversation about exclusions?

Kathleen Yaremchuk: No, and obviously when you see that it ranges from 79 percent to 0 percent, that's kind of interesting.

Reva Winkler: Yes. OK. All right, so the other thing potential threats to validity might be risk adjustment but it's a process measures are typically not risk adjusted so it's not a concern for this some of the other the measures in the eye care area are outcome measures. And so, consideration of risk adjustment is part of the evaluation.

In terms of meaningful differences, the purpose of performance measure is to make comparison among providers. And so, the question is has this measure is being used due the results – are they good enough or they able to make comparisons.

And so, the developers provided some data on the meaningful differences based on the size of the sample. So, I think here's the data actually on how many people were reporting? How many clinicians were reporting in PQRS? So, how many groups?

And so, what's the mean performance rate is and the standard deviation with the range and the interquartile range? So, this really gives you a sense of the variation and the spread of the data, a little bit more information than the single aggregate data point that you had and when we looked at earlier.

Kathleen Yaremchuk: So, we ask you …

Reva Winkler: I know we ask – and the developers are looking at, but can we assume that if there was a sample of 126 and each one had 10 that we have 1,260 patients that we have information on.

Sam, can you respond to that or somebody with you?

Sam Tierney: Yes. Can you clarify the question?

Reva Winkler: We have been asked before how much results we have in four years with PQRS, and it says based on a sample of 126 physicians and my understanding was that they had to report on 10. So, 126 times 10, does that mean, our experience with this particular measure is 1,260 patients, total?

Male: At least.

Sam Tierney: So …

(Douglas): Hi, this is (Douglas), I apologize. The sample is just based on having a minimum of 10. So, the range that – the physicians can have to be included is much higher than that.

Reva Winkler: OK. So, so we still don't know the total sample that we've had for the four years?

Sam Tierney: So, we can pull that time at PQRS reports, so just to – I know this question came up earlier and since then we have been able to pull up the full details of the report. The reporting rate in 2012 among eligible professionals was 2.6 percent and I know the data we provided in the opportunity proven section came from 2012.

There has also since been an experience reported published in 2013, so there is data on reporting rate in 2013, and then it has gone up a bit, it's now 4.6 percent of eligible professionals.

And the eligible professionals for 2013, was around 85 professional. I don't believe we have at least in the experience before, I don't believe they provide data on the number of patients that means, if they primarily provide data related to the professionals reporting in the program.

I'm not sure from our sample, our testing sample if we have information about the number of patients.

Reva Winkler: OK. I guess – OK. So, if it's 85,000 in 3 percent, is that the numbers you quoted?

Sam Tierney: Yes, 85,000 and 4.3 percent for 2013, the number was actually higher in 2012. It was 97,000 eligible professionals and 2.6 percent report rate.

Reva Winkler: And what – is the eligible professionals – is that by specialty or could that be anyone? Could a colorectal surgeon decide they wanted to report on this?

Sam Tierney: So, it's actually related to who treated patient with LME, so they do look at the whether or not the diagnosis was available, I think to identify eligible professionals. They may actually look across specialty.

Reva Winkler: OK.

Sam Tierney: So, they might determine, you know, it varies across the different measures. I imagine the based on the measure they would look at who they might expect to report on that.

So as imagine (inaudible) some specialties, so I imagine this measure include primary care and probably also the specialty of otolaryngology and that figure of the 85,000 or 97,000.

And one thing to keep in mind I'm sure, the reporting rate across the overall PQRS program is relatively – was relatively low in 2012 around 30 percent.

So, this is obviously a lot lower than that but it's existing group primary care physicians, they have a lot of other measures that they can report on.

And so, they may pick something that is more germane to their practice or some – one of the chronic conditions that they see more patients in. Or even they might report more on the measures group reporting option which allows or a little bit of easier if you will reporting modality. And the AOE measures was just included in a reporting group for us to 2015 program but it is – it's new, so it's not include in that data.

Reva Winkler: OK. All right. So, thanks very much, Sam. So, those are the potential threats to validity as you think about how valid your – your evaluation of validity for this measure should include those things. And so, any other thoughts before we move on to another criteria?

OK, the next criteria is feasibility.

(Crosstalk)

Sam Tierney: I'm sorry to interrupt you. But you don't mind if we could go back to the exception issues just because I know there were some concerns in order to cross all the measures and I thought it might be helpful to sort of explain the methodology …

Reva Winkler: OK.

Sam Tierney: … behind this acceptance if you don't mind.

Reva Winkler: Sure, go ahead.

Sam Tierney: OK. Thank you so much. So, I can appreciate the concerns that were raised about the exceptions and I just wanted to explain a little bit about the PCPI methodology for exceptions which was used to as a basis for the development of these measures.

So, we have exceptions included in measures, they are use to remove a patient from the denominator when the patient does not receive a therapy or service and the therapy or the service would otherwise maybe be appropriate.

But there are specific medical or patient or even system reasons that may dictate the patient meetings this service. So, in this particular instance I know that the comments included at some examples of why a patient medical reason, and why the patient may actually not need topical therapy as I think someone thought as comorbidity or contraindication.

And there may also be patient reasons why a patient may not need that and I think there was I mentioned earlier for example of parents maybe not wanting that particular agent being used for whatever reason. So, that it comes for patient refusal type issues.

I will say that the exceptions we used are purposefully broad. We do include them to allow individual clinical judgment as it relates to individual patients. And we found that across sort of a physician community they are well supported and the concept is well supported to allow for that individual decision making.

I do know that there is some concern generally with exceptions about gaming. There is maybe some thoughts that perhaps people might to improve the look of their performance might put down exceptions when they're really were not any exceptions in place.

But we do have some studies from our own work as well as more status been gone in the U.K. where exceptions are used in their public reporting program that really shows that for the most part when exceptions have been use their – they've been more validated and the rates are generally pretty low.

And I know the testing data for this particular measure also indicates that the rates are that high. There's a huge range and I know that was one point that was mentioned earlier but the average is relatively low.

So, I just want to give that background because I know there were some suggestion of how they could be improve than we had made a decision as a measure developer in our – with the expertise of our measure methodologist community to not explicitly list all of the possible exceptions because it

maybe very difficult to come up with that laundry list. So, it seemed more appropriate to allow for that individual clinical judgment.

Reva Winkler: Comments from the workgroup?

I will say that this is frequently a topic of conversation among committees and other discussions within NQF because there are a lot of folks who really do not support having such broad exclusions for measures because it makes a little harder to understand what's being excluded and they're not as auditable. So, this is on going conversation.

OK, comments? All right, so, if we're – if there are no other comments on validity, we can talk about on the next criteria feasibility, and feasibility is about how – what are the burdens, what are the cost to collect the data, calculate the data and report the data.

And if usually, feasibility centers around the data source. So, Kathleen, Michael, your thoughts about the feasibility of this measure?

Kathleen Yaremchuk: I thought it was very feasible, I thought it would be able to garner from the EMR without difficulty. So, basically administrative data and wouldn't require a chart review.

(Crosstalk)

Michael Stewart: Yes, the codes are very clear – there's good codes for this, so it's not like you're going to get a bunch of crossover of other things. So, I agree this is pretty feasible.

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

So, last criteria is usability and use and (for) elements. One is, how is the measure being use? Is it being use for an accountability type of purpose and this measure isn't used in PQRS. PQRS is expanding in its accountability functions and many PQRS measures will be publically reported in the near future and be – and included in the value-based payment modifier from CMS so, as account as accountability applications.

The other things we look at under usability and use are potential unattended consequences. And the trends, is this measure actually driving improvements, you know, what's the effectiveness, what's the impact?

So, those are the elements of usability and use that you want to think about, Kathy and Michael, your thoughts on usability and use for this measure?

Kathleen Yaremchuk: I think it's important in terms of once again unattended consequences, you know, the issue for me antibiotic overused and resistance. So, I think it's important in terms of high quality and also efficient in terms of resolution of a problem.

Reva Winkler: Yes.

Michael Stewart: I agree. I agree, I think this is a very good measure. It's the right thing.

Reva Winkler: OK, thoughts for anybody else?

Michael Stewart: And the other reason – yes.

Reva Winkler: Yes, please continue.

Michael Stewart: The other reason that was that was brought up, you know, this whole issue, people are coming in with ear pain and it gets diagnosed, you really don't want to take somebody who's got some other cause of ear pain like referred tooth pain, and be getting all those patients oral antibiotics.

Some topical drop, you know, it's not going to really change the whole, you know, the whole resistance of the bacteria in the patient and have also systemic side effects. They won't be effective for the pain and the clinician will have to – if the pain is caused by something else, the patient will have to go somewhere else because clearly the list harm and best for the overall health care system to give somebody a course of drops and have it not work and give somebody the oral antibiotic and have it not work.

Reva Winkler: Great. OK. So, any other thoughts on this measure before we move on to the next one.

And the next measure is 654, again, we're talking about acute otitis externa and this is the systematic antimicrobial therapy avoidance of inappropriate use. So, this time Seth and Michael are the discussants.

So, this measure is the percentage of patient's age two years and older with a diagnosis of AOE who are not prescribed systemic antimicrobials. And so, we'll start with evidence.

Seth, Michael what are your thoughts?

Seth Goldberg: It's the same study as for the topical and the evidence, again, is a very good showing that the addition of systemic antibiotics for uncomplicated cases of acute otitis externa provides no benefit and carries with it significant risks that we already discussed.

Michael Stewart: Yes, I agree. This is basically a flipside of a previous measure and we've already been through it, I agree.

Reva Winkler: OK, all righty. Then the other thing and their importance is opportunity for improvement and we can see that data from the PQRS program over four years certainly improved but how would you interpret the current performance or the 2012 performance that 73.9 percent.

Seth Goldberg: Again, I think there's significant risk for improvement and there maybe – those are overall performance and that says a request fact that otolaryngologist are doing these 90 plus percent of the time and other traditions and other specialties may have a lower levels and (inaudible). So, I think there's great improvement here.

Reva Winkler: OK.

Seth Goldberg: Also things …

Michael Stewart: I completely agree. Yes.

Reva Winkler: OK. All righty, so I think that covers the importance criteria. So, the next one again is we'll look at reliability and validity, the first consideration under

reliability is specifications is similarly specified as with the measure, thoughts on the specifications, Seth and Michael, anything to be considered?

Seth Goldberg: Only the same issue with the exclusion.

Michael Stewart: Exactly. Yes.

Reva Winkler: All righty. And I think we're going to see some more detailed data when we get further down the page. Reliability testing again, done in a similar fashion with the results in the, you know, above 0.9 for both the individuals and the groups in the PQRS program.

So, any questions or thoughts about on the reliability, empirical reliability testing, and the results?

OK, all right. This is an opportunity for you to ask any question for the information, too. So, be sure that you'll understand what's being conveyed. Again, face validity, we had face validity assessment and no specific empiric testing.

Again, we look at the threats to validity, we see the exclusions and they did provide you some frequency of exclusion – specific exclusions. I think we're sort of have this conversation. I'm not sure if there's anything to add.

And again, also, here's a little bit more a detailed data from the PQRS programs in terms of the, again, somewhat lower number of clinicians.

Sam, do you (think) that was in here. I don't – do we have a year – is that the 2012 data?

Sam Tierney: Its 2011, this data that was analyze …

Reva Winkler: OK.

Sam Tierney: … signals and the ways analysis was done on 2011 data.

Reva Winkler: Yes, but the stuff from meaningful differences?

Sam Tierney: That's 2012, yes.

Reva Winkler: OK. That's 2012, OK. So …

Michael Stewart: Yes, I thought that this detail on the exclusion the means are good that there's a pretty low overall acceptance rate. There's obviously a big range, you know, 40 percent, 60 percent of people – the high was – the high number of exclusions but somewhere is lower than zero and the mean was quite low.

And probably in practice, that's reasonable, 3 percent to 4 percent of patients are going to have an exception where you would – where it's appropriate to prescribe systemic.

Reva Winkler: OK. That's good. That's a kind of helpful, you know, evaluation particularly for the rest of the committee to be able to best interpret that data.

Seth Goldberg: Yes, the other aspect of this is that – having this data may – I feel that identified physician outliers who would benefit from education.

Reva Winkler: Yes. OK. And one thing about PQRS is participation is increasing, particularly as a penalty start to kick in for nonparticipation this year and the next couple of years. So, we should see, you know, larger – greater participation and it would be interesting to see what did the results data is with larger numbers of clinicians reporting.

OK, anything about the reliability or validity of this measure? Questions or concerns? Again, I think feasibility is pretty much the same. Is there anything in it that you'd want to add or same thing – the same conversation we have at the previous meeting?

(Crosstalk)

Reva Winkler: Yes, usability and use similarly?

Male: Yes.

Reva Winkler: OK, I'm not – yes. When they're …

Michael Stewart: Similarly, they're distractible. Yes.

Reva Winkler: Yes. When they're groups of measures like this sometimes it, you know, you have one conversation applies to multiple measures. OK.

Male: Right.

Reva Winkler: Any last minute thoughts before we move on to another measure? And we're going to move over to another set of – to another topic of otitis media rather than externa. OK, then I think Michael used to witness. He's trying to ...

Michael Stewart: Yes, you know, I think …

Reva Winkler: We can …

Michael Stewart: I'm taking take of my conflict, so we can just move through in order. That's fine.

Reva Winkler: OK, all righty.

Michael Stewart: Thanks for trying to accommodate. I appreciate it but we can just move forward.

Reva Winkler: OK, thank you so much for being with us. OK, so our next measure and the next three measures are about otitis media with effusion. And they really all have a similar theme and it's just that whatever medication is. The first one is antihistamines or decongestants, avoidance of inappropriate use.

So, this is the percentage of patients aged two months to 12 years, so there's an upper age limit. With a diagnosis of OME who are not prescribed to recommend it to receive their antihistamines or decongestants. So, this is – I think it's Kathleen and Todd, this is your measure? So, you want to start with the evidence?

Kathleen Yaremchuk: Todd, do you want to do this one?

Todd Rambasek: No, you can start. That's fine.

Kathleen Yaremchuk: OK, all right. I think there is good evidence for those who are inappropriate use in terms of several different things particularly issues of non-improvement, as well as risk associated, more with the decongestants in children than with the antihistamines.

Reva Winkler: OK, thoughts from anyone else? Do you feel that the evidence is sufficient to support the measure?

Todd Rambasek: Yes, I think there's adequate evidence but this is not beneficial. I think it's reasonable to use it as a quality measure on that basis.

Reva Winkler: OK, any other thoughts from anyone else?

Michael Stewart: Yes. Yes, it's Mickey here. I guess my only thought, I agree that data is good and it clearly is not helpful. I guess the only thing is we're really talking about over-the-counter medications here, which, you know, people take for the common cold and for allergies. They're really not that costly. It really not that risk.

So, I mean, if we really had to choose something that's not really important thing to educate doctors and parents and patients about – this one doesn't, you know, certainly it's not the highest – of the ones we're doing today.

Having said that, there's good evidence that's not helpful, there are potential side effects and I'm not opposed to going ahead. But this at least on my – in my – in that sense, this is one that's much less harmful and much more sort of low stakes. I know what the good things about that.

Reva Winkler: OK.

Todd Rambasek: I agree with your statement except I would differentiate the first and second generation antihistamines. Second generations are exceedingly safe and the first have overdose potential so.

Male: Sure, sure.

Kathleen Yaremchuk: And I think (inaudible) with the other one, so I think the only concern I have is lumping the antihistamines and the decongestants in terms of harm.

Todd Rambasek: You mean you're saying that decongestants are more harmful?

Kathleen Yaremchuk: Right. Well, more of a concern. I think there's a – even a warning against them. I looked it up, decongestants in a certain age group in the pediatric population.

Todd Rambasek: Sure.

Reva Winkler: OK, all right. So, moving on to opportunity for improvement, we really don't have any specific information from the use of this measure in any particular population. It's not in use on any of the federal programs and not publically reported. So, what the developers have provided is a 2013 study that does provide some data on how clinicians are behaving in this – the management of this condition.

So, I think the reason we have the criteria for opportunity for improvement is it really – is the question is how big of – you know, what's the quality problem? How big of a quality problem do we have in terms of – is it worth the benefit to have a quality measure because it's addressing and important area of practice that – where performance should be a lot better.

Todd Rambasek: Can I take that one?

Reva Winkler: Sure.

Todd Rambasek: So, the studies freely available on the internet so I pulled the study. And in table 3, they go – they do have the data that was presented in the worksheet. OME used by watchful waiting and the overall it's about 90 percent of clinicians in the study chose watchful waiting for otitis media with effusion.

But if you look right into that at avoidance of decongestants and antihistamines, they had 98 percent compliance. And that was a total sample, you know, with or without no matter what feedback they give the physician. So it didn't seem – so I guess there's a question of is there adequate practice gap?

Reva Winkler: All right, thoughts from anybody else?

Male: Yes, that's actually interesting kind of goes with what I was saying but this may not be a really high stakes problem.

Reva Winkler: OK.

Todd Rambasek: And same thing is going to come up with the steroid discussion, which is the next discussion, but all those steroids have great toxicity.

Male: Yes, and they require prescription, too. They require physician intervention.

Kathleen Yaremchuk: I think the issue about this and we may get into it later but they – I think the developers said that this would be a paper review. And so, the question comes up on the electric health records if it's over-the-counter, would it be captured, because you can put over-the-counter meds in the electronic health record. Would it be captured or not and if it requires a paper chart review is that, you know, problematic.

Seth Goldberg: Yes and some insurance company point of view. If it's over-the-counter, it can't be captured. And the insurance company can only capture pharmacy data for prescriptions only.

Reva Winkler: OK. All right, other thoughts on opportunity for improvement or we can go on to what you're starting to talk about? I think it might be the specifications – the reliability of the specifications. I think – we've certainly seen with other types of measures where it concerns about being able to capture data around over-the-counter medication.

Todd Rambasek: Before going on, it's …

Reva Winkler: Sure.

Todd Rambasek: … speak a little about the opportunities for improvement further because I think they're going to resonate throughout these three measures.

The (FAR) study that was cited was a study to see if clinical decisions support increased the adherence to clinical practice guidelines. So, it's somewhat of the tough population and that all of the people in the study were familiar with

the guidelines. They knew what they're supposed to do or not supposed to do, and they simply sought to see if clinical decision support through the EHR would change that.

So, I suspect that number is probably of a bit of an underestimate. Do the Hawthorne effect and just the population they looked at.

But they are – we have some data that have not been published which come from work being done by Jennifer and Shannon, at Harvard, we have a paper we're ready to submit to pediatrics on this which involves analyzing the National Ambulatory and the National Hospital Ambulatory Medical Care Survey National Hospital Ambulatory Medical Care Survey, so some big databases with tons of pediatric visits.

And the antihistamine use eliminating decongestants for the moment was 9.5 percent of visits for OME did have antihistamines used and that include the both prescription and non-prescription. About 40 percent of those were non-sedating antihistamines. And the odds of receiving an antihistamine went up by about fourfold if you had a diagnosis of OME.

It was felt that about one in nine visits for OME had an unnecessary antihistamine that was used and that's unpublished data but it's – they're pretty solid numbers from a national several – from some national databases. So, the numbers are not huge, but it's probably a bit higher than what's reflected in that (FAR) study.

The other point I would just make is that there is a prevalence issue here and that OME is otitis media effusion is pretty ubiquitous that somewhere up to 90 percent the kids are going to get those at some point.

If you just look any year randomly a kid 15 percent to 30 percent of them have it, and you know, most recent numbers of about 25 million children under age five in the U.S., it's a big item even it's low percentage points.

The average youngster from some studies gets four episode of OME per year and spends 25 percent of their days with some form of middle ear effusion.

So, I just bring that out to push some of this and in perspective and I'm sure that (Jennifer Chen) would be willing to share some of the data that would be helpful to the committee.

Male: I think that would be helpful.

Todd Rambasek: Sure. I can – we can follow up with (Dr. Chen) and so I think as long as it's kept confidential and just for – the only issue becomes I believe the minutes of this meetings go up for public view, is that correct?

Reva Winkler: And the meeting that they are discuss at including this one are public.

Todd Rambasek: So, these comments I think were fine but I'm not sure that (Dr. Chen) would be happy to have her manuscript – in pre-publication manuscript appearing for public view on this.

Reva Winkler: Yes.

Todd Rambasek: So I think we figure that out offline but maybe there is something feedback on perhaps ways to share this information without having at all, you know, align and sync or just put up for public view.

Reva Winkler: OK. Yes. We can talk with you offline on that.

Todd Rambasek: Thank you.

Reva Winkler: Sure.

Male: And they can take away as we really don't enough data.

Reva Winkler: Yes. But any data would be particularly helpful so I think we'll try and figure out the best way we can accommodate (Dr. Chen's) need but provide the information to the committee.

OK. Great, anything else before we move on? We can go on to reliability, validity. Any comments from the workgroup Kathleen taught on the specifications.

Kathleen Yaremchuk: Well, the specification is kind of go back with that if you can't capture the OTC part of it. It makes it difficult.

Sam Tierney: So this was Sam Tierney with the AMA. I just wonder if I could clarify the focus of the measure because I think I kind of appreciate the confusion about the capturing the over-the-counter piece of it. So, the measure focuses on the physician action. So, it looks at whether or not someone was recommended to receive antihistamines or decongestions or what if they were maybe prescribed that by the physician.

So, it does not actually look at, you know, on the back end whether or not a patient actually got this over-the-counter medication. Because that was run into some feasibility issues, given the nature of the medications that many of them are over-the-counter. So, it really focuses on the physician action either they are recommending that the patient receive it or they're prescribing.

Kathleen Yaremchuk: No, I guess I understand that but I'm thinking from electronic medical record point of view, a recommendation in the assessment or plan of a note, they not be captured whereas in previous ones or subsequent ones so in a prescription was given you're able to capture the ICD-9 and the prescription.

So, yes, I understand that it's a recommendation but that requires a paper chart review and that makes it more onerous difficult to obtain compared to one where you can capture it electronically.

So, there was never any questioned about whether it was recommended or not recommended. It's just capturing the data.

Sam Tierney: Great. So that's a good point. I will say that what we've presented for you is the measure for endorsement using paper medical record?

Kathleen Yaremchuk: Yes.

Sam Tierney: So, it does involve that level of detail. I do think there would be, you know, maybe an interest in the future because potentially classified the measure for other sources. It has its electronic health records and there are some claim specifications available but we had testing data on the use of the measure

using paper medical record. So, that is what we have currently available related to this specifications for the measure for your considerations for endorsement.

Kathleen Yaremchuk: Yes. We had noted that previously.

Reva Winkler: OK. And for these measures empiric testing of reliability, it's a little bit different on what you saw previously. This particular measure, it was tested at the level of the data elements which is acceptable because, again, I think because it's paper based, it was looking at the inter-rater reliability of two independent chart of structures for the different data elements.

Data elements – empiric testing of data elements is allowable. But the highest rating eligible would be a moderate. It does not qualify for a high rating.

And so, you can see the data that they present on – they present agreement as well as the kappa scores which is an analysis of how much of the agreement is real versus perhaps by chance. And so, this is a very a typical type of study for chart obstructed measures.

Comments around the empiric testing of reliability for this measure?

Kathleen, Todd, any thoughts there? Any concerns?

Kathleen Yaremchuk: No.

Todd Rambasek: No. I don't have any.

Reva Winkler: OK. So, from anybody else? OK. So, validity again is, you know, the specifications related to the evidence and then empiric testing of validity as we saw before this measure was just assessed by for face validity, so the highest rating on validity possible would be moderate.

We do see some addressing some of the potential threats to validity with the discussion of the exclusions though we did not see an analysis of the frequency probably because the measure really isn't used, and so there is a lot of data in that realm nor do we have much information around meaningful differences.

So, are there any other questions around, you know, validity for the measure or reliability? For many of the workgroup, do you feel like you understand the criteria? Do you understand the information provided and we'll be able to evaluate the measure appropriately? OK.

Male: I think so.

Reva Winkler: OK. Good. Feasibility, Kathleen, Todd, I think you sort of touched a little bit on data source, what are your thoughts of feasibility?

Kathleen Yaremchuk: You know, we should be thinking about it, it was – when we talked about paper charts, you know, we have an ICD-9 and you choose it. Some paper charts may do a verbal or a text diagnosis and not the ICD-9. So, I would assume, I don't know if you would then and we could ask because they do look to see what it was built out there as the ICD-9?

Because I could see where some people may say serious otitis, they won't say otitis media with effusion or they may use some other terminology that may (tolerate). But I guess if they've done chart reviews in the past, they have a methodology regarding that.

Reva Winkler: Sam, did you want to comment?

Kendra Hanley: This is Kendra from the AMA.

Reva Winkler: OK. Hi, Kendra

Kendra Hanley: I have something important to consider – hi – is, you know, when we specify our measures, we look to specific them true to the clinical intent of the measure and we try not to allow for practices that maybe not true. We correct coding practices.

So, I think it's important to acknowledge that where there maybe an issue on how data is coded is actually separate. It's separate from a measure issue.

So we typically aim to focus and follow the coding at how the diagnosis should be made. What diagnosis should be included to capture the population

we're looking for measure with the understanding that the coding issues would need to be handled separately.

Reva Winkler: OK, any other questions or thoughts?

Michael Stewart: This is Mickey. I understand that but I think the concern is we're talking about sort of I'm not sure which – if we're talking about feasibility, et cetera. If we recognize that there is a lot of overlapping code or issues but we're really not going to be able to measure and I think it would – I understand that's not really primarily a measure. It's huge but certainly, if just turns out that, you know, there is not a good code for what you're trying to measure, it could be a big problem.

Reva Winkler: You know, there some ambiguity …

Michael Stewart: So, I think in that circumstance. It is the measure issue if that was the case. It's not here, I'm just saying if it was.

Seth Goldberg: No, I don't think there is an ambiguity regarding the group of code that we've been used for the diagnosis but rather – if I could, they have abstracted information from the written record. It's not being taken from, you know, the billing, codes or, you know, whatever an insurance company can abstract in the process.

Insurance companies are now looking at – they're using empiric evidence-based guidelines to determine necessity of care and use that data. They'll use the codes. They will use the pharmacy billings and so forth. So, that data can be used to meet these criteria if it's available.

But I think if all this has to be abstracted from paper documents and, you know, based on cost benefit analysis, their doesn't seem to be value in doing this for this measure.

Reva Winkler: OK. Certainly consideration for the committee, any other thoughts on feasibility, then usability and use as we talked about the only use that was indicated in the submission was the measure used in ABIM self-directed

performance, the improvement module, the (PIMs). It's not publically reported. Any thoughts on usability and use of this measure?

Seth Goldberg: And provider education.

Reva Winkler: OK. All right, these are considerations because we – at the in-person meeting we will ask that this workgroup members and the lead discussants are really provide a good overview of each of the criteria and the measure so that the entire committee has an understanding of the issues and then you would be voting on each of the criteria to lead to your recommendation on whether to endorse the measure or not. So, that's – we will be discussing each of these for the benefit of the entire committee going forward.

OK, any other thoughts before we move on to the next measure?

OK. And these three measures are really set up very similarly so the next one six by six around systemic corticosteroids avoidance of inappropriate use and I don't think we necessarily need to go through of a things of the measures where they're very similar and repeat ourselves but I think for this one our discussants are Todd and Kathleen again, and so, the question is on the evidence for this measure.

Todd Rambasek: I think the evidence is very strong as multiple reviews, meta analysis based on, you know, 10 plus randomized controlled trials and it's widely agreed upon, so I think the evidence-based is special and strong.

Reva Winkler: OK. Comments from anyone else? OK.

Michael Stewart: I agree.

Reva Winkler: All righty. So, the question here from this measure is, you know, opportunity for improvement, again, we don't have data from the use of this measure in any specific population, again, quoting the (FAR) study perhaps if there is the data that we talk about from Dr. (Chen), did somebody might want to volunteer to help the workgroup that would be particularly helpful.

Todd Rambasek: Sure.

Male: Yes, so – I'm sorry, go ahead.

Todd Rambasek: I was going to comment on the (Chen) data or would you like me to wait on that?

Reva Winkler: Go ahead …

Male: Go ahead.

Reva Winkler: … show the data.

Todd Rambasek: So there's a few sources of data here. Dr. (Chen) actually just this morning I received some preliminary numbers from the National Ambulatory Database that I referred to before and actually systemic steroids used was pretty low for OME visits. It was only 3.2 percent. It was much higher for visits about twice as high for visits where OME existed than it didn't but the absolute number of 3.2 percent was fairly low.

The (Lannon) study did have some information which showed 5 percent used but it range from 0 percent to 62 percent attending on the practice they looked at and then – I'm sorry the (FAR) study – (Carol Lennan) study, I don't think we discussed yet, that's a primary care network study. I looked at two pediatric networks to see some of the feasibility issues of OME measures and they had found that systemic storage will be using five percent with a range from 0 percent to 62 percent of the practices.

The (FAR) study, I don't believe that provided data on steroids.

Michael Stewart: You're right. It didn't.

Todd Rambasek: It's critically not being used in a big way. So a lot of variability, but again, we're facing something for a highly prevalent condition in children that could have rather serious side effects in this case or adverse events it says here whether it's for something that carries no benefit

Reva Winkler: OK. Thoughts on workgroup, but thank you for providing that data, it's a big help I think.

Male: Yes. Thank you very much. That's very helpful. I agree. I went through the (FAR) study and I could not see any specific information. They just talked about how many people did watchful waiting which was, you know, roughly 90 percent. But then of the people who didn't do watchful waiting, they presumably did a variety of other things of which steroid use would've been one of them.

So steroid uses some fraction of a 10 percent who didn't do watchful waiting which would pretty much agree with the data you presented of 3 percent and 5 percent. So we're in the, you know, 3 percent to 10 percent range of people doing – using steroid use. So that's a valid point for discussion. Is that high enough that it's worth attacking? Is there any thoughts on that?

Reva Winkler: Thoughts from the other workgroup members?

Male: Yes. All right. It's a great question. I mean, I agree that this is a much higher risk thing that should be avoided. But if we're at a 3 percent use range, we just really work that. I think it's a very good question. I don't have an easy answer, yes or now, but perhaps not.

(Michael Stewart): I have a way of starting to get as a question which is, what is your perception of the trend of this? Like, if it's trending down, then, I mean, do we think it's trending down? Do we think – I spoke to one of my partners about this and his sense was that it is trending down. And so whatever was …

Male: Yes.

(Michael Stewart): … you know, higher in 2004, lower in 2010, and so maybe it's – so maybe there'd be 2 percent in 2017 without intervention.

Male: Yes. The word is kind of at about this. I think that's true.

Male: The word out for watchful waiting alone, or is it out for any of the specific measures?

(Michael Stewart): Different question.

Male: Yes.

(Michael Stewart): And I think oral steroids.

Reva Winkler: OK. All right.

Todd Rambasek: But is that among otolaryngologist or along primary practitioners? Because my informal survey of practice patterns amongst colleagues was that ENTs don't do it. But occasionally, we would still see a family practitioner do it. Is that your sense?

Kathleen Yaremchuk: I don't know. I think we also think that the ENTs are better performers. But when you – I did a survey of my department in terms of other things and I found out it went from zero. I don't think we know.

Michael Stewart: Yes. I would tend to think that the pediatricians, family practitioners, and otolaryngologist would not be that different of this measure would be my opinion because I think the otolaryngologist primarily doing it, a lot of pediatric otolaryngologist are pretty up on the guidelines and things that – I don't think there's going to be a big difference between the group personally. That's an opinion.

Todd Rambasek: No thank you. That's helpful.

Reva Winkler: OK. So thoughts? Anything else before we move on to discussing the specifications? Again, I think this is analogous to the ones we talked about before anything more you wanted to bring up or discuss about specifications for this measure about systemic steroids?

Kathleen Yaremchuk: It's a little bit more difficult because I'm going to say we have a collective data and so it's hard to say about whether there's a lot of exclusions or some of the other things that we talked about in the previous measure.

Reva Winkler: Yes. Right. Yes, we don't know the frequency that are being used.

Kathleen Yaremchuk: Right. Right.

Reva Winkler: OK. All right. So again, reliability was done, interrater reliability, paper abstraction with the data being presented. Validity again is phase validity and we don't have any information on exclusions or meaningful differences.

So any thoughts or questions from the workgroup members on – in reliability or validity of this measure?

Michael Stewart: I think what data we do have that they both appear to be reasonable. Reasonable reliability and reasonable validity.

Reva Winkler: OK. All right. Then moving down the feasibility and usability and use, is there anything in addition to what you discussed with the prior measure specific to this one perhaps around feasibility of data collections?

Michael Stewart: It should be more feasible since its prescription medication, right?

Reva Winkler: Well, it's still a paper-based chart measure.

Male: But I agree that it's still going to be more – potentially be (inaudible) potentially because there's no OTC use going on here.

Reva Winkler: OK. Any other thoughts around feasibility or usability and use? OK. Somebody was going to say something?

Seth Goldberg: So the risk associated with the use of steroids are such that I would think that the extra time and extra chart reviews could be justified.

Reva Winkler: OK. All righty. Usability and use, any comments there? All right. Then we can move on to our last measure which is 657. Again, otitis media, but we're talking about systemic antimicrobials this time and appropriate avoidance thereof.

So Seth and Michael, I think those are your measures. Do you want to just comment on the evidence and then anything else that you think might be different about this measure compared to the others?

Michael Stewart: Seth, go ahead.

Seth Goldberg: Yes. You know, go ahead, Michael.

Michael Stewart: So, you know, this is one that – in my opinion, the evidence is consistently good but not necessarily great on this measure. You know, the guideline is a recommendation versus strong recommendation. There are some evidence that actually there is some benefit, you know, in terms of more rapid resolution of the effusions.

I think people had generally moved away from it. And I think that there's – the guideline as endorsed by all the major studies, and I think the evidence is good but this one to me a little bit less of a slam dunk just from the evidence standpoint, other ones we've talked about tonight or this afternoon, it's tonight.

Seth Goldberg: Yes I agree. That was one of my reservations about it as well is that the issue of short-term benefits, so really, it's a matter of weighing the risks of side effects and consultations against the short-term benefit.

And since effusions tend to resolve within three months anyway, what is the point of putting a patient on an antibiotic? Again, the same thing, watchful waiting appears to be the best way of managing the uncomplicated otitis media with effusion.

Reva Winkler: Great. All right. Any other thoughts?

(Rich Rosenthal): It's (Rich Rosenthal). Could I comment on the evidence please?

Reva Winkler: Sure.

(Rich Rosenthal): So the group may not know but we are in the process of updating the guideline on which a lot of these measures was based. The original otitis media with effusion guideline was published in 2004. And we have a fairly advanced version of an update that's now going from some of the final stages of birth and it is multidisciplinary.

The statement in that guideline has been changed to a strong recommendation against antibiotic use. And it's based largely on the most recent Cochran

review which comes from 2012 included 23 studies of antibiotics versus placebo.

And as was pointed out, there were some small short-term benefits that we're seeing and even some small longer term benefits with some of the outcomes. But the most important finding in the Cochran review is that when you look at outcomes that are important to patients in particular, hearing levels and needs for tympanostomy tube surgery, both of those were not affected by the use of antibiotics.

So if we focus on the patient-based outcome measures, there really is no justification to use the antibiotics despite these somewhat short and limited term benefits that you can see if you just focus on the resolution of effusion at a single point in time. So I just wanted to make that clarification.

Reva Winkler: OK. Thank you. Any comments from the workgroup?

Seth Goldberg: That's helpful.

Reva Winkler: OK. Yes. OK. Then opportunity for improvement. Is there unpublished data in this – for this area that you can share?

(Rich Rosenthal): So I'm going to assume that was addressed to me …

Reva Winkler: … right, yes.

(Rich Rosenthal): There is no unpublished data but there are published data.

Reva Winkler: OK.

(Rich Rosenthal): So the (FAR) study had an antibiotic rate of 12 percent which was pretty low. But again, that's in a pretty savvy group that was the given the guideline and then sought to see if decision support made a difference.

The (Carol Lennan) study that was also published looking at some of the measures was interesting. And they had found that they are corrected – their adjusted estimate of antibiotic use was 32 percent in the primary care pediatric

networks. And that ranged anywhere from 0 to 50 percent based on the practice.

So there do seem to be some significant use of antibiotics still going on. And I think the overriding issue is the bacterial resistance problem which really is an overriding concern and judicious use and the appropriate use in this case. But we don't have data yet from the other national databases on this.

Reva Winkler: OK. Thanks for – OK. Comments from the workgroup on the opportunity for improvement here? All right.

Michael Stewart: I think there's an opportunity for improvement. I think – yes.

Reva Winkler: OK.

Michael Stewart: It sounds like a bigger one than steroids. Is that what the data suggests?

(Rich Rosenthal): Yes.

Reva Winkler: OK. All right.

(Crosstalk)

Michael Stewart: … and certainly, that would be my experience.

Reva Winkler: OK. OK. If we're – if you're finished talking about that, let's just look real briefly. Is there anything you'd like to comment on about the reliability and validity? Anything about the specifications for this measure?

OK. So …

Michael Stewart: No. I think this is pretty straightforward.

Reva Winkler: OK. So it's the same kind of thing. Thoroughly, with the validity and the potential threats to validity, again as I said, when we're in the in-person meeting, we're going to want to go through these and whoever is presenting and discussing the measure is going to want to just, you know, present the

information so that everybody on the committee understands the characteristics of the measure so that they can make an informed evaluation.

So any comments on feasibility of this measure? Is there anything different with this particular measure compared to the others? OK, or similarly, usability and use?

Male: As feasible and usable as the others in my opinion.

Reva Winkler: OK.

Male: Maybe more or because it requires for – maybe more because it requires prescription more easily extractable than some.

Reva Winkler: OK. All right. Any other comments on this measure or any of the measures we've talked about today? OK. Well, we have gone through all five of the measures and this was sort of an abbreviated process compared to what we'll do with the in-person meeting because as I say, as a workgroup, we're asking you to become familiar with these five measures so that you can represent them and present them to your colleagues on the committee at the in-person meeting going through the criteria and help them understand the various issues of the various criteria so that the evaluation is done by the committee as a whole.

Similarly, the folks in the other workgroups are taking care of the measures. You're not looking at in details. So everybody is taking a share of the workload. But we will be going through – for each measure, we will be going through the criteria and asking the entire committee to vote on how would they would rate the based on the information after the entire has had an opportunity to discuss.

So this is what we're preparing you to do. Is there anything else that you think would be helpful to get you ready for that in-person meeting and to do these evaluations?

(Crosstalk)

Male: You know, I think that …

Male: Go ahead.

Reva Winkler: Hold on a sec. Somebody was asking will we be doing what?

Seth Goldberg: Will you be adding today's comment to the evaluations for each of these measures?

Reva Winkler: Probably not specifically.

Vy Luong: So this is …

(Crosstalk)

Reva Winkler: Yes, Vy Luong?

Vy Luong: Sorry about that. This is Vy Luong. So to the person that asked that question, we're not going to – we will be posting up the transcript on SharePoint and on the public page to the discussion that we have today. In addition to that, we do have comments from the survey from your colleagues that are posted up to the measure worksheets in the preliminary analysis section. If you have your computer up right now, you will see on the webinar that under use and usability, we do have committee pre-evaluation comments from you and your colleagues. I hope that answers the question.

Reva Winkler: Yes.

(Michael Stewart): And I had a comment and that was that several of these or not several but, you know, a couple of these are sort of the, you know, the inverse of each other. And it seems like it would be a little more efficient rather than have two people talking about using topicals and then have two people talk about not using systemics. I mean, there are two measures that they're so closely related that – and the data is the same and the feasibility is the same.

And so could we collapse some of that? You know, it just seems a little artificial to go through that. And the same thing with the data on OME and some of the other things. Does that make sense?

Reva Winkler: We can say how we might want to do that. We'll talk with the co-chairs and see how we can maybe be efficient in discussion so we aren't repeating ourselves I think.

(Michael Stewart): Right. Because some of the evidence and stuff like that, it's the same evidence that we just have to talk about.

Reva Winkler: Right.

(Michael Stewart): What's distinct about this new measure instead of going through everyone of them in detail every time.

Reva Winkler: OK. All right. Any other questions or issues about evaluation process and preparation for the in-person meeting? OK. Vy, I'm going to hand it back to you then.

Vy Luong: Sure.

Reva Winkler: And it looks we're going to finish a little bit early today.

Vy Luong: Sure. So I'm going to hand it over to Kaitlynn.

Kaitlynn Ector-Robinson: OK. So hi everyone. We want to take the time to open up public comments. So operator, do you know if anyone is on the line?

Operator: At this time, if you have you a comment, please press star one.

And there are no public comments at this time.

Vy Luong: OK. Thank you everyone for joining the call today. As you know, the next activity for ENT committee is the in-person meeting. And that is on June 3rd and 4th, so within the next two weeks. If you have any questions, please feel free to reach out to any of us and please make sure that you register for the in-person meeting. If you need the link to that information, I can get that to you. So just please let me know.

And I guess that ends the call and we'll give you back 30 minutes of your time. Thank you again (inaudible).

Male: OK. You have a great day. Bye-bye.

Female: Thank you.

Vy Luong: Thank you.

Male: Thanks everyone.

Reva Winkler: And thank you Michael for calling from Israel.

Vy Luong: Yes. Thank you, Michael. Sorry about that.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END