NATIONAL QUALITY FORUM

Moderator: Ashlie Wilbon
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12:00 p.m. ET

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

(Suzanne Theberge): Hi, everybody. This is (Suzanne) of NQF. I'm here with (Evan) and (Reva). Welcome to the Third GI/GU Steering Committee Conference Call. Thanks for joining us today.

We're going to dive right in to the measure evaluation of the call, but first we just need to call roll for the committee so we have that on record and then we'll just check, have the developers check in as well. Andy Baskin?

Andrew Baskin: I'm sorry. This is conflict of interest or just?

(Suzanne Theberge): Oh, no, just roll call.

Andrew Baskin: Oh, it's OK, just roll call, but I do want to remind everybody that I cannot vote on this particular measure so when you count quorums or vote, don't count me.

(Suzanne Theberge): OK. Thanks, Andy. (Chris)?

(Christopher Saigal): Yes.

(Suzanne Theberge): (Lilliana)? (Zahid)?

(Zahid Butt): Yes.

(Suzanne Theberge): (Robert)?

(Robert): Yes.

(Suzanne Theberge): (Nancy)?

(Nancy): Yes.

(Suzanne Theberge): (Edward). (Johannes)?

(Johannes): Yes.

(Suzanne Theberge): (Jennifer)? (Rick)?

(Rick): Yes.

(Suzanne Theberge): (Elaine)? (John)?

(John): Yes.

(Suzanne Theberge): (Ann)?

(Ann): (Stewart).

(Suzanne Theberge): And (Phil)? OK great. Thanks everybody and I know we've got several folks from ActiveHealth on the line. Can you just introduce yourselves real quick so we know who is here.

(Bonnie Veer): Hi, this is (Bonnie Veer) from ActiveHealth.

(Suzanne Theberge): Great.

George Wu: Hi, this is George Wu from ActiveHealth.

(Suzanne Theberge): OK. Anyone else?

(Ann Pelchy Cameron): (Ann Pelchy Cameron).

(Rene Asera): (Rene Asera).

(Ann Pelchy Cameron): Just logged. Just signed in.

(Suzanne Theberge): Oh, great. Thanks, (Ann).

Male: (Inaudible) from ActiveHealth.

(Suzanne Theberge): OK. OK. Anyone else? All right. Great. So, just the usual quick housekeeping notes. Put your phone on mute if you are not speaking if you can and then also please don't put us on hold, so we don't get your home music on the phone.

So, the agenda for the call today is to discuss measure 622 and then we just want to take a few minutes to get your ideas for areas for future measure development. So, with that said, I am going to skip the test vote because I think you all know how to vote and then just turn this over to (Chris) as the co-chair and (John) to the lead discussion to get right into measure 622.

(Christopher Saigal): Great. Thank you. So, (John), if you won't mind giving us your opinions about this measure 622, upper gut/GI study in adults with alarm symptoms.

(John): Sure. So, this is the 622 measure, which is an upper GI study in adults with alarm symptoms. When we all met in person, we reviewed this particular measure and there were some questions that came up particularly on denominator and inclusion/exclusion criteria.

The developers have made some changes that I like to review or/and actually let me just state exactly what the measure is. The percentage of patients in the overall and high-risk population with GERD who have alarm symptoms who have had an upper GI study, the one change that's occurred is instead of having one single denominator, there are now two denominators, general population and the high risk. The other, the committee recommendations we have with the developer was that they should include chronic GERD patients and it has now been defined as such.

We communicated that the exclusion should be clarified as previous malignancy that has now been clarified as metastatic malignancy. Barrett's

esophagus should be included and it has been removed from the denominator exclusions in those patients. And let's say the, it now includes all patients.

I believe we had a comment about that should include patients below the age of 18 and they've submitted some further criteria for inclusion. The one thing that I would like to get some follow-up from the developer was around the addendum that's dated 1/11/2012 about separating the denominator into two populations. They said testing of this measure with the new denominators underway so I don't know if we have any further update about how that testing looks.

(Bonnie Veer): This is (Bonnie Veer). Should I respond?

(Christopher Saigal): Please do.

(Bonnie Veer): So, we are in the process of testing, however, we weren't certain whether this measure was moving forward and we have not finalized the results of that testing, but we can certainly provide that when we – when we know whether which way the measure is going to be going.

(Christopher Saigal): Can you tell us what the – what the testing would look like? Are you going to actually do that?

(Bonnie Veer): Yes, it's similar to our traditional testing methods where we take a look at the patients who fall into the denominator, who were who – and who also fell into the numerator and we look at the various portions of our rule algorithm and see whether they – whether they fell into the numerator and denominator appropriately using our algorithm, which is quite complex.

(John): Thank you. I think I'll probably just do a brief review of the measure. We talked about some of the updates. This measure is going to be coming out with data from different sources, everything from claims data often through management exchanges, patient surveys, health portal so it's coming through a lot of different data sources.

It appears that most of it is going to be coming out of electronic health records and I don't believe there's going to be a whole lot coming back from patient

self-reported data that that is part of something, which is called My ActiveHealth. Why is this measure important? I think the idea behind this is to figure out if the patient had early malignancies specifically their high gastric cancers or lower esophageal cancers and the idea is to find those patients sooner rather than later and people who are at risk for developing these are people who have chronic GERD and the patients who have alarm symptoms and the alarm symptoms here have been defined in the general population associated with dysphagia, iron deficiency anemia and weight loss.

The high-risk patients include those who are obese, male, age greater than 50 and there's pretty good evidence to support that those are the patients pretty much most at risk. I thought the idea is this is a national measure. I believe I've reviewed everything that's been in the – in this particular measure. I think when it first came through there is questions about how specific it was going to be in order to really get after the population of interest and I think the developers have done a much better job in being more focused around some of the inclusion and exclusion criteria.

I think the biggest question I have is, you know, how well this will actually do what it's intended to do because it's really looking at any sort of upper GI study to figure out if someone has got cancer. That may or may not be the most sensitive and/or specific test available, but from a population standpoint it appears to make more sense than widespread endoscopy for these patients, but I think that's a question that's still up in the air a bit so I'll probably pause there just for discussion or questions.

(Christopher Saigal): This is (Chris). I have a question, he had raised an important point last call about measures brought forward that could be perceived as proprietary so I'll – the developer could just make a statement about how proprietary the, you know, personal health record information or nurse call in mind, are those questions and sort of data source components published and replicable by other organization that don't have access to ActiveHealth?

Female: Yes. So, our PHR and assessments that are delivered by our disease management nurses where you see active health versions of those things, they are proprietary; however, the questions and data points and elements that are

needed to answer the questions appropriately and to have them count in the appropriate manner for the numerator or denominator or exclusion are publicly available.

(Christopher Saigal): OK. So, basically whatever a patient report via their portal, those kinds of data elements are recorded as patient reported data that another party could basically set their own portal that would put some of the information. Is that right?

Female: Yes.

(Christopher Saigal): Thank you.

Male: Just to follow up on (Christopher's) point there, will the algorithm be available in the public domain or is it by request?

Female: The algorithm is currently publicly available.

Male: Thank you.

Female: As are the code sets.

(Christopher Saigal): OK. Any other questions in the group?

(Reva Winkler): (Chris).

(Christopher Saigal): Yes.

(Reva Winkler): Yes. This is (Reva). When the committee is finished, I just wanted to clarify something.

(Christopher Saigal): OK. Any other group questions right now about this? What do you got (Reva)? What's your topic?

(Reva Winkler): Yes. I just want to be sure that we're clear on the measure that the committee is evaluating because we have – there was the update with the two denominators now, but we don't as (John) mentioned have any testing data so I want the committee to be really clear on what you're voting on, but I would

ask in terms of the fact that we don't have any data that on the original measure I think they talked about the fact that they were out of the two and a half million patients there were only 392 that qualified in the denominator and I was wondering if we had some kind of estimate on the number that are likely to be in the denominator or the two denominators of the new version of the measure because that's a fairly small number.

(Christopher Saigal): Yes.

(John): That's (Reva's) point. Yes. That's why the follow-up testing for the new denominator was of interest to me. I mean that's still pending.

I guess one option is to take them one at a time to look at the general denominator and then look at the high-risk one once we have testing and just started out there as an approach.

(Christopher Saigal): Yes because we have information of general denominator at the high risk. Is that allowed?

Female: Ah, let's see what ActiveHealth can tell us.

(Bonnie Veer): So, we did find that in the new denominator when we split the two denominators out I believe it was roughly half and half of what you're finding for your total denominator.

(John): It's like 150.

(Bonnie Veer): Right. Give or take. Yes.

(John): You got what you give.

(Christopher Saigal): All right. Well, I mean I think it's – go ahead.

(Zahid Butt): This is (Zahid). So, is this the time to sort of discuss all the sort of issues, et cetera related to the measure or …

(John): Yes.

(Christopher Saigal): Yes, it's a good time, (Zahid).

(Zahid Butt): OK. So, I think I'm still not clear really what is the intent of this measure because the guidelines that are being cited clearly are very specific in use of endoscopy in patients with chronic GERD. So, you really have a very specific cohort of denominator cases that are defined as patients with chronic GERD and so I am not sure if I see any definition of what chronic GERD is in this measure.

There is a 12-month window within which the alarm symptoms are present prior to the measurement, but there's no specific definition of the GERD part of it. Now, if you go to 3B1, which says, you know, likely that demonstrate improvement in performance, there is language for example the developer is saying that for this measure examining the number of people with chronic GERD and alarm symptoms who had an appropriate GI study done, we identified all of 733 patients from the entire national book of business and who fulfill the criteria and then we found a compliance rate of 19 percent over six-year period.

Now, what that implies is that a compliance of this, it sort of, you know, I think it was mentioned earlier that maybe the objective of this measure is sort of global, sort of national measurement, but when you sort of get into compliance rates and so forth that is a very specific sort of thing that you are saying and so in that context, all these other types of tests and so forth I mean you wouldn't consider them as complying with the appropriate evaluation of a patient who has chronic GERD and needs an endoscopy because everything that's written here as evidence that supports this measure talks only about the appropriateness of endoscopy in chronic GERD patients really looking for pretty malignant conditions or even early malignancy in patients with alarm symptoms.

Male: I think that that's exactly right, you know, the data around the upper GIs and for elucidating this type of cancer doesn't anyone near as strong for this – for endoscopy.

(Zahid Butt): And also there are any upper GI tests including motility studies would actually make it into the numerator so I really …

Male: Yes.

(Zahid Butt): … don't know what the – what the measure is trying to do based on what the evidence will be cited. I sort of see it disconnect.

(Christopher Saigal): I see. So, the numerator is not – is not specific enough for what the evidence suggests.

(Zahid Butt): Or for that matter I think even the denominator in this context to me is not specific enough.

(Christopher Saigal): OK. ActiveHealth, do you have any comment about that?

George Wu: Sure. Hi. This is George Wu from ActiveHealth. So, for the two questions I'll just like to clarify the first question first regarding the definition of chronic GERD.

So, from our denominator description, our definition or the definition of chronic GERD is that you have the diagnosis in the last 12 months plus you have been on a chronic GERD medication either PPI or H2 blocker with the total supply of I'm seeing here is two to three, two months in the past 12 months in order to (identify), to qualify as a denominator. In addition to that, the denominator also includes weight loss and dysphagia from diagnosis codes or from our patient reported data. So, for the denominator perspective, that's how we define "chronic GERD."

The second question you have is regarding the compliance and I absolutely agree with you doctor about that. EGD is probably the only way to evaluate such patients. However, a lot of times with what we have been seeing with our big data analysis is that a lot of times we see actually – we usually see both codes and sometimes in our experiences that we see a gastric emptying code or barium enema, sorry, not barium enema, a barium swallow code and then we actually get feedback that they actually have endoscopy done either around that time that we actually for some reason did not capture that code

and that's – that's the reason why we included those and we realize that it's not appropriate and if you think that it's, you know, if, you know, this is a purely e-measure, we don't, you know, we don't account this kind of a variance in actual practice then we can actually take those things out as well to just include an endoscopy as a pure numerator completion criteria.

Male: Yes.

(Zahid Butt): I think along those same lines and in sort of I understand the denominator chronicity that has been defined. I think that if you look at the guidelines they would define chronic GERD as a little bit longer than 12 months, but perhaps we could accept your definition in that sense …

George Wu: OK.

(Zahid Butt): … and I think coming back to the numerator. So, one is the – of the various diagnostic studies, but even more problematic that I found was that if you had a gastrectomy for any reason, you are in the numerator.

George Wu: OK.

(Zahid Butt): I mean I don't see how that makes any sense.

George Wu: Yes, I mean that's …

Male: Yes, I think one thing we brought up last time was to at least exclude patients who have weight loss surgery, which is, you know, some of them are gastrectomy that's …

Male: So, they excluded that …

Male: Yes.

Male: … but I think that, you know, if you had partial gastrectomy for let's say peptic ulcer disease …

Male: Yes.

Male: … and nothing to do with GERD that patient will be in the numerator in this if I'm interpreting this correctly.

Male: I think so.

Male: I see. So, it sounded there's some really important points made here by the committee about the specific definition of the numerator. Measure procedurally if that means that we should just, you know, take a vote on the issues and they could bring the measure back, is that (Reva) what we should do?

(Reva Winkler): You know I think that you're talking about some significant changes to the measure both in the numerator and potentially in the denominator so we're perhaps, you know, speculating on a – on a completely new and different measure and I think it really wouldn't be fair to try and understand how that measure might behave going forward so I think that we need to have you make your decision based on the measure that's in front of you certainly with the understanding that we would be opened down the road to seeing a revised measure on the same subject that addresses some of these issues.

(Christopher Saigal): Yes. That's what I was thinking too. Any other committee members have comments or concerns?

OK, maybe we should just then move to a vote, keeping in mind that the measure developer has indicated willingness to modify the existing measure and bring it back and that we can't, of course, vote on what we don't have in front of us. It is also more time for testing as needed for one of the denominator measures.

So, I think (John) wrote the reliability. Do you want to walk through that (John) or we should vote? I think it's a better idea.

(John): Yes, I think we should probably vote. I think we reviewed it.

(Christopher Saigal): OK. So, reliability, about precise specifications and testing, this is probably the most important thing here.

Female: One.

(John): I thought there was a general vote first.

(Christopher Saigal): Ah, that's at the end, I think.

(John): I think it's supposed to be at the beginning.

(Christopher Saigal): Yes. That's right. Is that right, (Reva)?

(Reva Winkler): Yes, it's at the end.

(John): OK.

Female: Now, we're expecting eight committee member votes. Is there anybody who doesn't have access to the online voting? Oops, there we go.

All right. So, we have seven low and one insufficient on reliability.

Female: OK.

(Reva Winkler): And just to make it complete, could you guys vote on validity also?

Male: OK.

Male: Yes.

(Reva Winkler): Because a lot of sort of apply to both and we'll keep it nice and clean.

Female: Ah, one more vote. There'll be eight in all.

(Reva Winkler): OK. Because it didn't pass the scientific acceptability at this stage, we don't need to go further, but I think I hope ActiveHealth heard the message that the committee would very much like to see a revised measure with the feedback that they've given you and then with the opportunity to see how actual data looks with the revised specification in the future. So, any other comments from you (Chris) on that?

(Christopher Saigal): No. I just want to thank (Zahid) and (John) for some very insightful comments.

Female: OK.

(Bonnie Veer): This is (Bonnie) from ActiveHealth. Just a quick question. When we – If we are to go back and revise this just in the future the questions that are being brought up today were they were – they were not brought up to us previously other than the revised denominator, which would actually, it was actually suggested by the NQF that we revise the numerator and we came back with what we thought was a more valid breakdown of the – of the measure into two separate denominators with the exception of that suggestion.

We do request that we be given adequate time for testing and that some of the other comments and questions about the other pieces of this measure, they have been brought to our attention earlier that they were concerns by the NQF we certainly would have time to address them so we just ask for that going forward.

(Reva Winkler): Sure. We hear the comments. I think (based) on some of the feedbacks that is important as part of understanding the things that work and things that didn't work so well in the two-stage pilot and so we certainly appreciate your comments.

OK. So, (Chris), I think we're finished with all of the measures.

(Christopher Saigal): Yes.

(Reva Winkler): (Suzanne), was there anything else you wanted to bring up?

(Suzanne Theberge): Yes. In our project reports, we do generally include a list of recommendations from committee members of areas that they see as measured up, areas for future measure development, recommendations from the committee, this is basically just the list of your ideas. So, we wanted to just spend a couple of minutes and see what you all think we at NQF and you as a committee should recommend developers work on in the future in this field.

So, this, there's no formal kind of discussion. It is just if you have any ideas that haven't come up already throughout the discussions of this committee, you know, please just jump in and list them off.

(Reva Winkler): Yes. We review your discussions and if someone had said "Gee, you know, I wish we had a measure that looks like this," we'll capture that somewhere, but if you have any other thoughts about looking at the measures in these two topic areas what you saw versus what you personal experience and expertise can tell you might be called areas of quality concern or quality problems where a measure would be particularly useful in driving improvement, identifying those would be particularly useful.

If you can come up with things today, that's great. If you want to muse it over for a bit and then perhaps send us an email, feel free to do that. We're going to be summarizing all of your discussions and recommendations going forward.

(Johannes): So, this is (Johannes). I think one of the areas that seems most glaring and you probably cover this at other points when I wasn't on the call too, but is that really we're lacking outcome measures. We have a lot of process measures and for example in colonoscopy, there are measures of quality, but truly what we want to know is what are the outcomes and so, you know, do you actually find adenomas more relevant even than that is do you actually find cancers and given the how common colonoscopy is and how much we're supporting it as a screening measure and how good the data is that says that it actually works, but only works if it's done well.

So, I think to me colonoscopy is like the quintessential example of a high-value procedure with very dramatic outcomes where if it's done poorly or less than optimally can have negative consequences really highlights the fact that what we want is measures that do outcomes not just did you recommend the 10-year follow-up for somebody who had a negative colonoscopy, but you know, more appropriate and accurate measures of what the actual performance of the procedure was and, you know, we had that one mash up that try to get at some quality indicators, but it was really very confusing. The true outcomes, which are adenomas, were actually missing from that. So, I

think my recommendation would be that people look at outcomes rather than process, but I know that's been a theme recurrent throughout what we talked about.

(Reva Winkler): Great. Thanks.

(Robert): This is – This is (Robert). I like to second that opinion in particular. I think one of my biggest disappointments is that we weren't able to do something with that colonoscopy composite measure justifiably so I think the way it was – it was constructed, but it was one of the few elements here that I think had a component to it that could resonate with consumers as something that's directly meaningful to them and if a developer could indeed bring something like that back with a much more directed focus on outcomes, I think it would be a valuable contribution to getting consumers to even think about quality.

(Reva Winkler): Thanks very much. Any thoughts from anybody else?

(Christopher Saigal): This is (Chris Saigal) here. In terms of the urological side, there actually, you know, there's very few things in urology where there is a good process outcome link, but in bladder cancer, there are good data that shows that there is a problem with the process of care that for non-muscle invasive bladder cancer that specific interventions aren't getting done that improve survival for patients with bladder cancer and that is I think an easy win to target with the quality measure.

(Reva Winkler): OK. Super. Any other thoughts from anyone? Because these are great suggestions. This is exactly the kind of thing and particularly from the consumer perspective, I really appreciate your input.

We're going to take the next week to 10 days to pull this together into a report that will go out for public comment so if something occurs to you that you'd like to offer in the next week or so, feel free to drop us an email and we'll be happy to include it. We will be summarizing your evaluations and put this out for public comment and as like I say 10 days or so, it will be a 30-day public comment period.

You're certainly welcome to alert your colleagues to review the work that you've done and submit comments. We look for comments from anyone in the public sector who has an interest in the topic area. Once we have those comments, we'll be coming back to meet with the group by another conference call to review those comments to see if the comments have any influence on the recommendations you've made, perhaps you'd like to revisit some of your evaluation or reconsider some of your recommendations based on that feedback from interested members in the public.

So, we'll be doing that before the, a measure then go out for a final vote at the NQF membership. So, that, those are the next steps going forward. Are there any questions from anybody on the committee?

OK. That's pretty much all we have here. Andy or (Chris), anything from you all?

(Christopher Saigal): I just want to thank all the committee members for their faithful and loyal service to the NQF.

(Reva Winkler): All right. OK. One last …

Andrew Baskin: And I'll just – I'll just echo that. Thank you.

(Reva Winkler): All right. One last task is operator, is there anyone who would like to ask a question or offer a comment for public comment?

Operator: At this time, if you would like to ask a question or make a comment, please press star one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Male: I have a question.

(Reva Winkler): OK.

Male: When does the measure once we revisit this particular measure that we just submitted this ActiveHealth, when can we revisit this measure once we revise it?

(Reva Winkler): I can't give you an exact time right now. We'll just – We'll have to see what NQF schedule of looking at measures going forward. Right now, we've got several activities underway in terms of, that will impact some of the processes and the consensus process and specifically about the schedule for submitting measures so you'll have – so we'll be able to let you know in the future, but I can't tell you right now.

Male: Thank you.

(Reva Winkler): Are there any other questions? All right. Andy or (Chris) if that's all, I think we're able to sign off a little bit early.

Andrew Baskin: I like that.

(Reva Winkler): And really – And we really do appreciate all the time that you all have put in and thank you very, very much for your thoughtful considerations of the measure.

(Christopher Saigal): All right then, everyone, have a good day.

Male: Thank you.

Male: Bye-bye.

Female: Thanks, everyone.

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

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