NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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4:00 p.m. ET

Operator: Welcome – welcome to (inaudible). Today's call is being recorded. All lines will remain open throughout the call. All lines will remain open throughout the conference. You may press star six to mute and unmute your line. Please stand by.

Suzanne Theberge: All right, good afternoon everybody and welcome to – I think we are having some technical issues.

Male: Wow.

Suzanne Theberge: Could everyone be sure to turn their computer speakers off? Put them on mute or turn the volume down on them and keep your telephones on mute when you're not speaking please. OK.

Please stand by while we troubleshoot the sound.

Male: Operator, if we can just mute all the lines except for Suzanne and the two up line that we dialed in although we can get started that way. Suzanne?

Suzanne Theberge: Pull them in. So can you pull them into a private?

Can you hear me?

Female: Hi am I in the main line?

Male: Yes.

Suzanne Theberge: OK, great. Hi, everybody. Sorry about those technical difficulties. I think we've gotten them resolved so we're going to go ahead and get started. Welcome to the GI/GU Steering Committee conference call. We're going to be discussing the comments received on the measures. So, this is Suzanne Theberge, the project manager. With me on the phone are Reva Winkler and Evan Williamson, the rest of the project team. And now, I'd like to go ahead and just call roll so we know which committee members are on the phone. Andy Baskin?

Andy Baskin: Here.

Suzanne Theberge: Great, Chris Saigal. Operator, can you make sure that all the lines are open so that folks can speak?

All right, Chris Saigal?

Ma'am are all the lines open?

Chris Saigal: Can anyone hear me?

Suzanne Theberge: OK. Yes, now we can hear you.

Chris Saigal: OK.

Suzanne Theberge: All right, Liliana Bordeianou?

Liliana Bordeianou: I'm here.

Suzanne Theberge: All right, Zahid Butt.

Zahid Butt: Present.

Suzanne Theberge: Great, Robert Ellis?

Robert Ellis: Here.

Suzanne Theberge: Nancy Faller.

Nancy Faller: Here.

Suzanne Theberge: Edward Gill? Johannes Koch?

Johannes Koch: Here.

Suzanne Theberge: Jenifer Lightdale?

Jenifer Lightdale: Here.

Suzanne Theberge: Richard Luetkemeyer?

Richard Luetkemeyer: Here.

Suzanne Theberge: Alayne Markland?

John Morton?

Anne Pelletier-Cameron?

Stuart Reynolds?

Stuart Reynolds: Here.

Suzanne Theberge: Phil Schoenfeld?

All right, great. And for the developers, do we have AMA-PCPI on the line? Do we have ActiveHealth on the line?

(Bonnie Veer): Yes, this is (Bonnie Veer).

Suzanne Theberge: AHRQ? I think they're going to be joining us later actually, and NCQA.

Female: Yes, this is NCQA.

Suzanne Theberge: Great. Thanks everybody for joining us this afternoon. Just a couple of housekeeping things. We are – all lines are open on this call so please put your phone on mute when you're not speaking and please don't put us on hold as usual because we'll get your hold music.

So with that said, I am going to turn the call over to Chris and Andy, our co-chairs to begin the discussion.

Andy Baskin: Do we …

Suzanne Theberge: Chris and Andy are you …

Andy Baskin: Yes, we're – we'll I'm here and I presume Chris is, I guess, I got to say one of the – which measures we're going to start with so I know whether Chris or I is going to start the conversation.

Suzanne Theberge: OK, sure. We are going to start with measures 658 and 659.

Andy Baskin: OK. So, this is Andy. This is at my alley and it's like – I think I'll do the GI ones except for the Hepatitis A measure.

Female: OK.

Andy Baskin: The vaccine measurement. So, the comments so in 658 and 659 are – are kind of lumped together, there are similar comments on both. If you had perused the comment sheet, I think they fall into a couple of baskets.

One is the issue of the potential for quote, unquote "gaming" which would essentially, the idea that that lack of history for prior colonoscopy is essentially can move someone out of the – out of the game here at least for the forward thinking one which is the one that's the colonoscopy is every 10 years after a normal colonoscopy, the recommendation. The idea that it's really not looking back at – at the prior, at the performance of that particular colonoscopy whether it was premature is essentially lumped into this kind of gaming idea or at least less value.

The other issue that's brought up by some of the comments is the exclusions and the ability to exclude based on – more specifically the medical reasons. I don't think there was much concern about the other ones. And that that's, once again, an opportunity to potentially game, I guess, is a tough word but it's a word that's used by some of the commenters.

Now, on the other hand, there were several commenters who commented that the measures were great the way they were and were very happy with them. So I don't know whether any one now wants to discuss the – these types of comments – the ones of concern here. I think they do reflect some of the same things we talked about at our meetings.

And I'm not so sure that – that anything new came out of the developer's responses. At least I didn't think so, not that they're needed to be, but that we – we already identified these inadequacies in the measure but as was mentioned in somebody's comment somewhere, you know, don't let the (inaudible) get in the way here. And that our decision was based on the fact that these were good measures as is as the way they were presented. They could be better and we've provided that feedback to the developers for the next round of these measures. But that, you know, we had to make a decision on the measures as is as are they good enough to endorse and – which is what our prior decision was.

So, any comments beyond that from the group or – regarding these two measures, 658 or 659? Or did I get it right?

Suzanne Theberge: Yes. Yes, we'll be returning to these measures at the end of the call to discuss the eSpecs but we're going to go over that comments first.

Andy Baskin: Yes. Anyone want to make any comment on the comments?

OK. Well, as I said, I don't think there was any new ground in what was presented in the comments so I can appreciate if there are no additional comments to be made.

Suzanne Theberge: OK all right. Then I'll be …

Andy Baskin: Go ahead. I was going to say, what's the next – oh the Hepatitis A what I think is – Chris is going to do that because I have a conflict here.

Suzanne Theberge: Yes, yes. We're going to move on to 635, chronic liver disease.

Chris Saigal: OK. So I guess we – this is one – there's a question about whether this is a national level measure or not.

Suzanne Theberge: Yes.

Chris Saigal: And that's one of the comments that the NQF is - was endorsing a measure that don't – the measure of quality at the national level because there's no comparative group and no one holds accountable. And my reading of it - of this measure was that it could be used, that the plan level was being used the plan level and we specifically asked whether it could be exported to other settings outside of an, you know, provider to have an ActiveHealth contract.

So, I'm assuming that it could be used easily at the - at a more granular level than the national level. So, it's like an important concern if it can only be used as a national level measure. I think it sounds like you have been using a different context. Any more comments?

Reva Winkler: Chris, this is Reva from NQF, I just like to clarify a bit. In terms of the endorsement that NQF grants, we do - we - part of the specification is the data level is indicated. And so if indeed this measure is only indicated in the national level, then even though it maybe used elsewhere, the endorsement does not extend to that which is why we've got an issue here.

Frankly, NQF does not have any other measures that are endorsed solely at the national level. That is really in – the national level of analysis is really a roll up of data regional population level measures. And as you indicated, this measure is clearly been used at the health plan level and it is – was the testing information that was provided to us was that of to health plans in an employer group.

And so, I think that at this point, for NQF to endorse it as a national level doesn't really serve anyone's particular purpose. If the developers were inclined to indicate that it is also a health plan level, that would be included in the endorsement and then the committee can make their final recommendation on that.

Chris Saigal: OK. So I've – I think that the developer actually helped us on the line. Can they make that amendment to their measure like in view of the health plan level too?

(Bonnie Veer): This is (Bonnie Veer), can you hear me?

Male: Yes.

Female: Yes.

(Bonnie Veer): Yes, so that's fine with ActiveHealth.

Chris Saigal: OK. So, assuming that ActiveHealth is able to make that amendment, can I ask if the committee has any objections in – with that basis? So, I'm not hearing any objections. I think it's a good point that we clarified and we can move on.

Male: But Chris, I have a point of clarification on this measure from the developer – one of the developer's responses.

Chris Saigal: OK.

Male: So this was in response to (Matt Austin's) question from the Armstrong Institute and in the response, the developer states that because this is an eMeasure, and I wanted some clarification on that. I didn't realize that this was an eMeasure in the terms how we define eMeasures.

Chris Saigal: Well, is it – can I ask a person from ActiveHealth, is it specified as an e-measure?

(Bonnie Veer): Sure. This is (Dr. Veer) from ActiveHealth. Well, I think – we're using the eMeasure verbiage sort of on the technical basis because all of our data sources are electronic. So, whether we're getting even – given feedback and survey data, we – it is entered electronically in the – into the numerator and denominator information. And all of our measures are – the data for all of our measures are run through an electronic (inaudible).

Male: My understanding of eMeasure definition is that that would only – what you just described would only qualify for it to be sourcing its data from electronic sources but does it have an HQMF version of the logic and does it have value sets defined which are following the eMeasure's framework?

Female: I'm sorry. What was the question?

Zahid Butt: My question is that eMeasures have a very specific definition and constraint as to what the framework should be in terms of how the logic get specified and how the value sets get developed. Does this measure follow all those attributes?

Reva Winkler: Yes, it does. Zahid, this is Reva. I don't believe this measure was submitted in HQMF format.

Zahid Butt: So would you - would you consider it an eMeasure then Reva?

Reva Winkler: NQF has defined eMeasures as needing to be submitted in HQMF. So if it's not, then I would say, "No, it's not technically what we consider an eMeasure.

Male: That would be my reading of it also.

Female: OK. My apologies, I didn't understand that there was an NQF definitions specifically that you were referring to.

Male: OK.

Zahid Butt: So and I think when you say something as an eMeasure, it has a lot of things that it needs to conform to before you can call something an eMeasure.

Male: Right. So there's a - so is there a request to change that verbiage or is that – was that further …

Male: I would suggest that in order to avoid confusion that this be rephrased as a measure that sources - uses data sources that are electronic I think that's as far as it can go as far I can see.

Male: OK.

Female: OK. If the – if the (inaudible) would like us to reword our response to the comments, then – that we're open to that.

Male: OK, thank you.

Male: OK. Are there any other concerns about that - that become an …

Zahid Butt: I think the biggest concern that was voiced, I think, was something which was discussed also that prior immunity, people feel that it would be unnecessary vaccination of folks who maybe immune already. If they want to get high scores on this measure since it's not addressing that particular aspect.

Female: If I could be allowed to comment to that and …

Male: Sure.

Female: … and we used to have immunity – prior immunity testing as part of the numerator for this measure because immunity testing to the Hepatitis A antibody comes to class as either a positive or negative result, not as a numerical value and lab test that do not come across as a numerical value, they're difficult to ingest in any sort of a meaningful way. So whereas in the past it could be allowed for it need to be testing alone so that, the actual surrogate for the enumerator. We were asked by the NQF to remove that because of the inability to differentiate a positive or negative test.

Zahid Butt: I think the intent of the comment is to see if there's a way to exclude it from the denominator in some sense because they don't require immunization.

Female: Agreed and …

Male: If there's a positive …

Female: Agreed and the – the same difficulty comes whether you include it in – as an exclusion or as a numerator inclusion. It's nearly a, you know, for the difficulty with the type of data it is. We do allow for survey feedback and patient feedback. We'll, from providers or patients, same with the (inaudible).

Male: OK. So we've gone over this a little bit as a group. Any other comments about this issue with prior immunization status or exposure status?

OK. As I hear – are you satisfied in terms of your concern?

Zahid Butt: I mean, I think it is still a concern. I'm still having a little trouble because the rationale that was given why a yes/no couldn't be accommodated is because it's an eMeasure. And if it's not an eMeasure, why can't that response be accommodated? A positive/negative response?

Female: It's nearly the way the data is codified. There are no eMeasures that can ingest apart from my knowledge that may ingest a positive or negative result from a linked value.

Zahid Butt: Right. But this is not an eMeasure though. We just determined that, didn't we?

Female: That will be allowed for (inaudible). It would be allowed for survey data as well.

Male: So it's limitation basically would be because there's no way to incorporate yes or no answers in your algorithm.

Male: Reactive or non-reactive, yes.

Female: I think (inaudible) to it. But it's a line code considering from across – there's a numerical value.

Male: I see. So for that part of it, you are using codified data?

Female: That's right.

Male: OK.

Female: And that's why we allow it for the feedback to, you know, for that – for any data gap.

Male: Right. And the issues that the value is not available, from prior status?

Female: That's right. That's right, you don't come across as a word, positive or negative.

Male: Right.

Female: It would be reactive or non-reactive.

Male: So I think that if I recall from previous conversation, you had presented some – or maybe I'm mistaken, but maybe you can clarify that what is your sense of – what percentage of people will have prior immunity and will get revaccinated if somebody wants to get their score up, or if they don't do that, then they would get a lower score inappropriately.

Female: Well, we would have to go back and reanalyze the data with this new question that you're asking. It would require a reanalysis of some of the test data that we've done already.

Male: Because I think that's really what goes to the heart of this question that the person who commented wanted to know because they are concerned that there will be excessive overuse of the vaccination for people who don't even need it or that people who will appropriately not get vaccinated will be (inaudible).

Female: I understand the concerns. I'm going to appreciate them. I hope that the steering committee can also appreciate that with this measure along with an (impact) measure that was under review for over a year and we're getting these comments in (inaudible) it would be difficult now to go back and rerun all of the data and retest at this point. I'm not saying that we couldn't do it for the future –for future reviews. But at this time, considering that it's been under review for over a year, we've been working on it for over a year so it would be difficult to do.

Male: Is there – this idea – is there any quote "general sense" in the population of literature about what's the preferences of the people that have had hepatitis …

Male: My guess is it's very population-dependent, some populations may have a very high incidence, others might not. I think if you went to certain areas where hepatitis A is more common and endemic, you could probably have

very high incidences. But in many other populations, you probably wouldn't have as high an incidence.

So, you know, it's OK I think as long as we can maybe have the developer later on perhaps look at that issue and see if – I don't know the process Reva, is it something which, it could get endorsed now and they could come back and do an update on it? Is that – is that something that can be done?

Reva Winkler: Well, at this point, we need the steering committee to, you know, look at the information, look at the comments and make a decision. You have recommended this measure, the question is, all of these issues have different ways, does that make you want to change your recommendation at this point in time?

Male: I – well, I personally don't think that it reaches the threshold of changing it for me.

Male: OK, did any one else change their minds at this comment? All right, so I guess we can just say that we understand and agree with the commenter and that the developer is aware of this limitation. And I guess we've heard some expression that they would be able to look at it in terms of feedback data over the next years. Is that what I understood correctly?

Female: Yes, that's correct.

Male: OK, all right. Well, if that's the case, then we should note that and move on, I think. So, the next one, is that the urine incontinence one?

Female: Yes.

Male: So this is measure 98, NCQA measure about assessment, characterization and plan of care for incontinence. So the physician who is in charge of this review can't come today, Dr. Morton. But I can summarize what the comments were in general about this. The biggest concern that's incremented is this kind of a check the box process of care measure. We've done a clear relationship to outcomes of care and there are some concerns that only measured women aged 55 and older and concerns that were pretty (topped-out) a bit. You

know, most of the people that report on PQRS are getting (tapped-out) in terms of their performance on it.

So, Dr. Morton has some comments about that which I can inform the group of. Basically, she does agree with some of them. The comment she has is that although it does apply to a specific population of women over 65, that this is where you feel out of the burden of illness. And it's appropriate to measure them and regarding the PQRS concern, she feels there might be a sort of group of people that are reporting. And that as PQRS is more widely implemented, we'll find gaps which I think is a reasonable thing to assume.

And in terms of the, you know, check the box measure, I do think that if you are to test into an evaluation and treatment plan for somebody who are incontinent, that is probably, we link to an outcome that matters to them. So – and then if it was talking about assessing that in general, it could be check the box. But I think that if you link it to a treatment plan as part of the measure that does go towards a relationship to an outcome measure patients would care about. Those are my thoughts about that.

Does the group have any other comments about that?

Nancy Faller: Yes, this is Nancy and I – I do have a concern also and have had a concern. I think there's a huge qualitative proof that's missing. I mean, you could say treatment but what is – what's the treatment that is given to the patients appropriate to what the patient's problem was and I do think that that's not evidence in the tool.

Male: Yes. Well, it certainly doesn't – you don't know anything about appropriateness, that's for sure. But I guess (inaudible).

Nancy Faller: So basically, you could – you could think you are doing well because you gave the person treatment but if you had a patient with urgent incontinence and you gave them pelvic muscle exercises, you haven't really done anything to help them just in fact that it actually maybe made it worse.

Male: Yes that's true. My sense is, is that what motivated the measure was the fact that this is under-recognized as a problem by women that they think of it as a

part of normal aging. And that having the discussion and formulating a plan represents a big evolution in the quality of care for them.

So, I would agree that you're heading towards the idea of, you know, what's appropriate, what's – you know, kind of help the person. What are the outcomes, indeed, that matter? I'm OK with this being a first step there. I don't know if anyone else has got a concern at that level.

Anne Cameron: Hi, Chris, it's Anne Cameron. I agree with you. I mean, this is – this is really a first step question where patient is assessed and given a treatment plan. Yes, the treatment plan might not be correct but usually the first step in treating incontinence whether it be a medication or pill for physical therapy, none of those things are harmful and they get someone actually identified as having incontinence. So, I like to measure the way it is.

Male: OK, anyone else? Nancy, does your concern rise to the level where you want to reconsider the measure as going forward?

Nancy Faller: Yes, what if? But I think if Anne supports this as a neurologist, that would factor on that.

Male: OK.

Nancy Faller: And I agree with it. I totally agree that the discussion is the beginning but if you have the patient want to discuss, I'm not sort of the patient all of the time (inaudible) to adequately answer that. Just that – yes, maybe like that. I just don't know.

Male: OK.

Nancy Faller: No, I would support the (answer).

Male: OK. All right. Well then, the next one is GI. And Andy, do you want to take care of that one, 2065?

Male: You bet. So …

Female: Actually …

Male: Oops, go ahead …

Female: Andy, let me clear it up.

Well, we just need to check and see if we got (Patrick Romano) on the line yet. He thought he might not be able to join until 5:00. (Patrick), are you there? All right, it's – what we – we'll have to do is jump ahead to the remaining issues and then we can come back to this at the, you know, as we get to 5:00.

Male: Yes.

Female: So we'll – I'll jump forward to the comments on measures not recommended which was 622.

Male: Oh, I'm reading the – I've read the comments. I don't remember any comments from 622, I'm sorry. What did I miss? I went down the entire list and read them all, it's …

Where there specific comments from 622 that I didn't see?

Female: Well, that would be in the end.

Male: The answer is at the end – oh, I'm sorry.

Female: Yes.

Male: Oh. So that puts me on the spot.

Female: Well, basically, we just, you know, we had – we have one comment on measure that raised some concerns about the measure and the interfacet proposal, the draft response and the memo. You know, we just want to make sure that response is OK with the committee. And, you know, it's a – or if the committee has anything they'd like to add.

Male: Yes, and I apologize for this. I actually – I – well I see this coming. I'm not supposed to be discussing this measure either because of the conflict, so I apologize.

Zahid Butt: So, this is Zahid. I think that the concern as I read it was more that perhaps the committee didn't feel later on that this was an important enough measure because of the small population. As I recall, that was not the main concern that we had. It was the specification itself, identify the numerator in ways that we thought would be highly inaccurate in getting – basically, this measure really gets to – if you have ALARM symptoms whether you're having endoscopy done or not, sort of the core of the issue.

But I believe that the numerator had things like, you know, you've qualified even if you had a gastric emptying study done and gastrectomy done and things like that. So, there were lots of assumptions built into the specification which I believe were part of the problem with this measure.

Suzanne Theberge: I think that – this is Suzanne, that sounds correct. I mean, is there things we would just wanted to get a response out from these comments or an – you know, if the committee has any added to the draft response in the memo? You can let us know now or you can let us know in the next day or so.

Zahid Butt: Yes, I didn't actually read the draft response in detail but I did read the comment and it looks like the comment assumes that because it was a small population that the committee felt in stage I, that was important but that in stage II, it changes mine. But I don't think that was the case.

Kendra Henley: Yes, yes that's correct.

We've – I mean in our job's response, you just suggested that, you know, that the measuring needed additional work that it was not (set identically) and the specifications were not precisely specified …

Zahid Butt: Right.

Kendra Henley: … and it passed the scientific acceptability criteria but …

Zahid Butt: Right.

Kendra Henley: … it did encourage the developer to bring it back in the future.

Zahid Butt: Right, right.

Kendra Henley: OK.

Well, you know, we do occasionally put some draft responses in the memo. So if you folks have any changes you want to make, just let us know in the next day or two before we finalize those.

I think the next area for discussion was the measure gaps in areas for future measure development. There were a number of suggestions for that. And basically, what we do with those is we just go ahead and add those to the report unless anybody has any concerns with those recommendations, you know. And we can also take any additional suggestions that you may have thought of since we last asked you.

Zahid Butt: So – all right, this is Zahid again. I think that one of the measures that was mentioned was the steroid-sparing use of – use of steroid-sparing drugs in IBD, and I think that's an important aspect to measure and I think it had the same issue in terms of the specifications, et cetera. So, I think, again, we agreed that it's an important measure to report, but I think it needs more work.

Kendra Henley: Yes. Actually, that measure was not submitted in stage II. It hadn't (inaudible) yet.

Zahid Butt: Right, I think – but I think one of the commentators assumed that somehow we sort of didn't think – I mean it implied …

Kendra Henley: Yes.

Zahid Butt: … that we perhaps, the committee, didn't feel it was important.

Kendra Henley: Yes, we can clarify that response …

Zahid Butt: Right.

Kendra Henley: … in the responses to the comments. We'll just let that commenter know it was not submitted, but we can …

Zahid Butt: Right.

Kendra Henley: … do it in the future.

Zahid Butt: Yes, I would tell that clarifying that would be good.

Kendra Henley: OK.

And there were a …

Andy Baskin: So while we're waiting for the (tip) from AHRQ, what – should we go to the eMeasure spec part or do we have another part that we have to do?

Female: No, I think it's actually covered. Unless there are any committee members have any other comments they wanted to address that didn't come up yet other than the AHRQ comments, then we can jump ahead to the eMeasure discussion and then come back to the AHRQ measure at the end of the call.

Andy Baskin: And I think that we already know that the measure, the colonoscopy index is not going to require anymore discussion at this level. It's going to be at the CSAC level, right, so we can tie that of.

Female: That's correct.

Andy Baskin: OK. Just want to make sure of that.

Philip Schoenfeld: This is Phil Schoenfeld. I'm sorry because I missed the first 10 minutes. What's going on with this measure at the CSAC level?

Andy Baskin: There was just a comment noted that while we got public comment, there's no more discussion at the Steering Committee level. Apparently, CSAC is – has chosen that because they've gotten since CSAC (just wanted to) discuss the issue. That doesn't necessarily mean – I don't know what that will entail, but that's a decision that's outside of this committee.

Philip Schoenfeld: What is CSAC?

Andy Baskin: CSAC is the committee that with this group reports to, the Consensus Standards Approval Committee which is the final endorser of the Steering Committee's recommendations before it goes to the Board of Directors. So that's the – it's the multi representation type of committee that does the endorsements. And then they are finally approved or not by the Board of Directors. So, it's a level above Steering Committee.

Philip Schoenfeld: Is there anybody in the Steering Committee who's going to participate in those discussions to express the views of the committee?

Andy Baskin: Yes. Well, I believe the co-chairs will. I certainly will because I happen to sit on the CSAC, but what I would presume that both of us will be invited to that particular CSAC meeting to discuss it.

Philip Schoenfeld: OK. Is it possible that I might be able to participate by teleconference just for that portion of the discussion?

Andy Baskin: I don't have the answer to that, but we can ask the NQF (offline) about that.

Reva Winkler: Yes – no, this is Reva – there's – CSAC meetings are public meetings and we'll be happy to let you know when it happens and when you can call in and what the agenda is.

Andy Baskin: Yes, I forgot about that. There are certainly public. The question is whether he has to be part of the public comment or whether he can actually participate in the regular conversation, I think, is really what he's asking.

Reva Winkler: Well, you know, it's still to get …

Andy Baskin: And I don't know the answer to that, so.

Reva Winkler: Yes. So, (determined) by the co-chairs.

Philip Schoenfeld: OK. I'll let you guys figure that part out, 0658 and 0659. Again, when I came on to the call, we had already moved on to other stuff. Any issues with those two?

Andy Baskin: It was really a rehash of the – you know, essentially things that we'd already commented on previously. There was no new ground here. And this committee acknowledge that and no changes are contemplated in our decisions as of the comments that we made today.

Philip Schoenfeld: OK. That …

Andy Baskin: It was just free acknowledge to, you know, the deficiencies of those measures, but that we let them – we OK them because they're better than what's not there and that the developers know that there is some improvements that need to be made the next time around, kind of where we left it.

Philip Schoenfeld: OK. Can I make one other comment though on the Colonoscopy Quality Index just real briefly?

Andy Baskin: I actually prefer not. This has been something that's been opened up so many times. It really should not come back to this committee for another discussion. But still, that opportunity will occur at the CSAC level. It won't do any good to comment at this level. It really won't.

Philip Schoenfeld: It – OK. I'm just …

Andy Baskin: I really don't want to open it up here. It's not – it gets out. It's gotten …

Philip Schoenfeld: OK, that's fine …

Andy Baskin: … (inaudible) for many times.

Philip Schoenfeld: Fine, that's fine. You can all breathe the sigh of relief. I'm not saying anything.

Andy Baskin: But I'm not discouraging making comments at the appropriate venue. It's just this is not the venue. The CSAC would be the venue.

Female: So, we'll follow up with the whole committee with the information on the CSAC call and that – when that's going to be discussed, we'll get that out to you pretty soon. We just have to finalize that.

Female: OK, eMeasures.

Female: All righty.

Andy Baskin: Yes. Where are we going with the e – I'm not sure where to take us to the eMeasures rather than it's the two endoscopy measures which are the eMeasures that we're to discuss.

Reva Winkler: Yes. This is Reva. If you recall, the Steering Committee listed that you wanted to see a crosswalk of the specifications from the eMeasure to the original measure. You did recommend the original measure but you had sort of held a recommendation on the eSpecs until you could look at the crosswalk.

The measure developers have provided the crosswalk. It is attached to your memo with the detail. And I know, Zahid, this is something you were specifically looking at. Have you had a chance to review it?

Zahid Butt: Yes, Reva, I have. And I must compliment the developer for doing a good job with the crosswalk.

So, it is, you know, well done and it is addressing some of the issues including a wrong code in the original measure which they have corrected. So, I think that it is much easier to follow now what it is and they have additional document that describes the changes they have made.

I do have one quick question if – I know that the AMA-PCPI is on the call that in 659 where they described – the measure sort of describes that it has to be an adenoma polyp to get into – the previous colonoscopy should have had adenomatous polyp. But in the value sets for the denominator, there are value sets that are just plain old benign polyps without stating that they are adenoma polyps. Does that mean that those nonspecific codes would still qualify for a denominator?

(Anoop Gupta): Hi. Dr. Butt, this is (Anoop Gupta), AMA-PCPI. Which are you referring to the colonic polyps value set, the individual code …

Zahid Butt: Yes. Yes, yes, the individual codes that are in there in the value set detail.

(Anoop Gupta): Yes, I think the denominator …

Zahid Butt: Their code is just for – it says adenoma – it says polyp – colon polyps, basically. So, I'm just wondering how is that used if it's – because the only way – the only place the colon polyp code gets in here is in the denominator of the previous colonoscopy, right?

The previous colonoscopy should've had adenomatous polyp by definition. And it's not clear of how that code that is not specific for adenomatous polyp but just for general colon polyps is going to get used.

Kendra Henley: Yes. Zahid, this is Kendra Henley. I could jump in.

You know, part of that is the limitation of the ICD-9 and ICD-10 coding. So, we did include – we actually chose to not include ICD-9 in this. We put ICD-10 in SNOMED.

Zahid Butt: Right.

Kendra Henley: And the ICD-10 that are included are, you know, how the adenomatous would be coded. Although, in looking at them a little bit closer right now, I see that they are not necessarily …

Zahid Butt: Right.

Kendra Henley: … (inaudible), although they would …

Zahid Butt: Yes.

Kendra Henley: … be appropriate codes to code adenomatous polyp.

Zahid Butt: Right. Right. But – So my concern would be that those nonspecific codes would potentially qualify a case in the denominator which would be contrary to the definition, essentially.

Kendra Henley: Right. So, this is where we get a little stuck between the recommendation for what terminologies we should use or what data types, and the information that

can actually be captured in that terminology. And I think we, you know, would certainly consider just taking out the ICD-10 in addition to the ICD-9 which we already did. And the (inaudible).

Zahid Butt: Yes, the nonspecific ones, I would recommend you take another look. But I think other than that, it looks fine, everything looks fine to me.

Kendra Henley: OK. OK.

Andy Baskin: Does anyone on the committee have additional concerns?

I certainly would like to have some – put my thanks into Zahid for clarifying this all for us. I know in the last meeting, you made it so that I understood exactly what the concerns were and I appreciate the fact that to the best of the ability of the coding, the limitations of coding that they (expect) concerns were addressed. And thank you again for that review Zahid. It's very, very helpful to all of us.

Zahid Butt: Thank you.

Andy Baskin: Then there's no additional comments now. Did we come to a conclusion yet on the eMeasures or are we going to have vote at some point?

Reva Winkler: We do need to come to a conclusion on whether to recommend those eSpecification as an additional part of the measure endorsement.

Andy Baskin: And do we – are we doing that on this call or are we doing that on a survey after the call, or how is that happening?

Reva Winkler: If you can do it on the call, that would be grand.

Andy Baskin: Well, I – there's no reason why not. If anyone – we'll call for a – yays and nays. But if anyone feels that they cannot give a yay or nay because they need some time then certainly say that as well and we'll let your vote come in later, I presume a reasonable period of time.

So I'm going to …

Female: Actually Andy, we've got an electronic vote set up so we can jump ahead to that slide.

Andy Baskin: Oh, OK.

Female: Anyone else who want to vote?

Andy Baskin: And we're doing both measures at the same time?

Female: Yes.

Andy Baskin: OK.

Do we know how many voting members we have today?

Female: I believe we have 12.

Andy Baskin: OK. Well, I see eight.

(Crosstalk)

Chris Saigal: I'm not on the computer anymore, but my vote is yes.

Andy Baskin: Thank you, Chris. So that, we have nine, that would be ten.

Female: OK. And I'm getting confirmation that we have 11 people who can vote. So …

Andy Baskin: OK. So we have one missing. Is there someone who's having difficulty voting or is there one person that feel, they cannot vote today for some reason or another?

Female: Or is there anybody who isn't …

Andy Baskin: Oh, they're ten, they're ten.

Female: OK.

Andy Baskin: So Chris would be 11th so that now we have them all. Thank you everybody.

Male: I went to the bathroom, sorry about that.

Andy Baskin: No, it's quite all right, appreciate it.

Female: All right. Great.

Andy Baskin: I mean, I guess – do you have to read that into the minute? Eleven yeses and zero nos, because you just did.

Female: Yes, thank you.

Andy Baskin: You're welcome.

Female: So those eMeasure specifications are now recommended as well as the regular measure specs. So, I think it this time we're going to need to return to 2065. Is there any body who's representing that measure on the phone yet?

(Jeff Skipper): This is (Jeff Skipper) from the AHRQ (inaudible) support line, I can represent (inaudible).

Female: OK, great.

Andy Baskin: Great, so let's open that one up. So there were, there were several comments here and I think the comments really had two types of comments. One was a more technical reliability testing comment of which I believe there is a response from ARC which even I may ask for a little bit of explanation of how they got that 27 percent. I'm trying to figure that out myself after having looked that it. And we'll do that in a second. I presume the others have the same questions as I have, which is a helpful explanation.

The other was a really I think there are related issues, but this issue of using principal diagnosis only versus principal diagnosis plus either a secondary or further down secondary diagnosis. And the fact that there are small numbers of which probably is partially a result of using only the principal diagnosis. And there are concerns that – that the way people code hospital charge is that– while, I understand the developers noted that you get a more homogeneous sample by using principal diagnosis. Only, the question is that it's so limiting that you get such a homogeneous sample that you actually don't get a true

representation which is what I'm reading between the lines of the commenters. And that it's not truly representation of the majority of GI bleeds (inaudible) just say, subset of them. And such a subset that it's not really representative of what's really going on out there. So …

Zahid Butt: And Andy – Andy this is Zahid. That – I think that this last comment that you just made, I think you really have to probably stick with the principal diagnosis for GI bleeding because this is an outcome measure that is measuring mortality of GI bleeding. And if the second risks are included and it really were not to be truly representative of mortalities related to GI bleeding, I mean there are people who are even questioning whether the mortality is directly tied to the GI bleeding they want to get down to that level of specificity, but I think the closest you can get to this specificity in terms of someone coming in with a major GI hemorrhage and what is the mortality I think you really have to limit yourself to the principal diagnosis. That's kind of how …

Andy Baskin: Yes and I understand that point. I guess the point I was making is as there are those that would say that all GI bleeding is due to something. In other words, is there truly ever a primary GI bleed and the answer is no because GI bleed is a fine, fine symptom I guess. But there have to be an underlying cause and is the underlying cause going to be the principal diagnosis which is often the case, as is often the case based on DRG reimbursement I might add as to whether that's a better diagnosis to use.

And therefore, are you really siphoning off these cases because it's actually more – it's actually beneficial for a hospital to use a – the cause of the GI bleed instead of calling it GI bleed when in fact they were admitted for GI bleeding yet, yet in reality of the underlying diagnosis is whatever. You know, whatever reason is causing the bleeding …

Zahid Butt: Yes, I could see your concern.

Andy Baskin: You know what I mean, now you – that is a primary diagnosis. So, in doing that yes, you get this homogenous population but is it really meaningful?

Zahid Butt: Right. No, I see exact – exactly your concern. But the contrary argument is that does it really matter if GI bleeding is number 10 on the list of diagnosis if the patient came in with the MI or CHF and died. So, would you then attribute that to GI bleeding?

Andy Baskin: You know that's a tough question. You come in with GI bleeding and it actually caused you to have CHF. Would you have CHF or would you have GI bleeding?

Zahid Butt: Right, right. But then at least, at least you would – at least you would be the principal reason for why you've came in would be GI bleeding. But if you flip it around and I agree with what you just said that many times the coding might be more specific than GI bleeding. But if they follow the coding convention and someone is admitted with GI bleeding often the diagnosis is not known at that point. So the principal diagnosis is really should be GI bleeding and then secondary could be peptic ulcer disease, esophageal varices, whatever.

(Crosstalk)

Male: That's not a discharge diagnosis. This is an admitting diagnosis.

Male: Right.

Male: … but often times you can't even figure it out.

(Crosstalk)

Zahid Butt: Right. I think the – I think the discharge diagnosis, the principal – the definition of principal diagnosis is that it is the diagnose that led to the admission after all the, you know, evaluation has been completed. So it's a discharge diagnosis really but it takes into account what the patient came in for. It's the principal reason why the patient came in for admission. That's the official definition of a principal discharge diagnosis.

Male: No, I understand that but if the patient came in with congestive heart failure and it turns out the congestive heart failure was caused by a hemoglobin of three from GI bleeding, what's the discharge diagnosis?

Zahid Butt: It would be congestive heart failure if they came in with congestive heart failure (inaudible).

Male: That's if the cause of it was high output congestive heart failure from anemia, from GI bleed. GI bleeding was the (inaudible) event.

Zahid Butt: Sure. No, I understand. No, no, I understand.

Male: I mean but that's – that's what happens though in the coding and that's why I, you know, especially if someone is going to be measured on the mortality of GI bleeding, then they're just not going to code people as GI bleeding when they die. They're going to use the other diagnosis when they have a choice. I think that's the issue that the commenters are bringing up and I frankly, having been around the way hospitals code and I'm not saying that in a interrogatory sense, I mean they're doing what they're doing. They're coding to maximize, you know, the reimbursement for the care that they did provide. That's how it works.

Well, let me ask the developer. I'm sorry I forgot your name already. I'm terrible with that. If you can comment first on that – that reliability specs that I know you – that there was an added note about to us as to – is, you know, just what's your response to that – the comments for.

Male: Sure. And unfortunately (Patrick) is really going to have to address this second issue on the coding. But on the reliability, the comment was about the overall reliability of the GI hemorrhage measure. And, you know, our comment is really tied to the fact that the reliability metric is not sort of an overall characteristic attribute of the measure but it's really an attribute of the measure when it's applied to a particular data set. And it's incorporated into the performance score calculations.

The thing that we focus on is, you know, how – how much useful information is there after this reliability adjustment has been taken into account. And so, that preventability table that was included in the response was just – and you attempt to demonstrate how useful information remains in the measure even after the reliability has been accounted for. And it just shows that if, you know, if all hospitals were to perform at kind of the benchmark level of care

based on the distribution that's remaining in the performance course after the reliability is taken to account. There actually is quite a bit of variability remaining which suggest, you know, the potentially preventive, you know, a preventability rate of a 20 some percent.

So, it's basically just the demonstration of the fact that there's a considerable body of useful information even accounting – even after accounting for the fact that – even they have for accounting for their reliability of the measure. The relatively small sample (inaudible).

Male: Yes. OK, I appreciate that. Anybody on the committee have any follow-up question regarding that or people OK with that explanation or response?

Male: Yes, this is – I have a question, is this using the risk-adjusted rates or is it non-adjusted rates?

Male: It's using the risk- adjusted rates.

Male: OK. So taking risk-adjusted reliability into account, there's still a 20 percent potential variation of a preventability type?

Male: Right.

Male: OK. Thank you.

Male: Exactly.

Male: OK. We're hearing no other comments. Thank you very much and I – so, I don't know how we're going to get to the other part of this. Other than our own internal discussion here and I'm not so sure that there's much more to be said about it. But does anybody else have any comments regarding this principal diagnosis issue?

Liliana Bordeianou: Hi, Liliana Bordeianou. I just wanted to make one comment.

Male: Yes please.

Liliana Bordeianou: Essentially, we're going back to the discussion we had at the very beginning. When you're measuring death it's hard to cheat on that number, but the question is, will the system be cheated by simply coding as you said in a different way? And I don't think it's NQF and no matter how good a measure we come up with, you know, if the hospital wants to cheat on coding to not report a death, they will find a way to cheat on coding to not report a death

But by the same token, I think that the measure in itself makes sense and yes, there are patients that have come in with massive GI hemorrhage. And when you measure the performance of all the services that are involved in the care of that patient, there is a very variability in care from hospitals to hospitals, based on volume, based on the resources that are available and that it's important to measure.

Male: Yes, and I agree. But the question is how much of the variability is related to differences in care and how much of the variability is related to differences in coding? In which case then the actual – there can be unintended consequences of this measure to be honest with you. It rewards good coders.

Liliana Bordeianou: Oh, yes, that's an imponderable.

Male: Yes. I – to me that's a major concern especially since the – it is such a not frequent occurring event to die from a GI hemorrhage in a relative to other diagnosis in the hospitals and other mortality causes. So that, you know, one or two cases make a big difference in your result because they are small denominators to start with.

I don't know how to resolve this but it's not just these measures, it turns out as some of the other part of measures that measure hospitalization rates that have similar issues as it turns out.

Male: So I think that …

(Crosstalk)

Male: I'm sorry Lilian, go ahead.

Liliana Bordeianou: Yes, I just said that that was a good point.

Male: So I think that the small numbers issued are different issues than the coding issue. But I think they do – that small numbers issue is actually one of the problems across the board in quality measurement especially when you get in to provider specific performance.

And so I think that there is that methodology that they (inaudible) in their response, the shrinkage methodology, I don't pretend to understand all of it but I have seen that use before to try to get around the small numbers issue. And maybe Reva could comment on that or the other folks could comment. But I think they get around that by using their shrinkage methodology.

Male: Any comments regarding that methodology?

Male: Yes, exactly. I mean the shrinkage methodology is intended to address the small numbers issue. And it's intended to minimize the likelihood of making invalid inference based on reliability adjusted risk, adjusted rate.

So, basically, what it does is it shrinks the risk adjusted rate to some shrinkage target which could be the overall meaning or it could be some regression determine mean based on hospital attributes. In this case it's just the overall mean.

So, basically, you know, if your rate is based on a small number of cases, your ultimate performance will be closed to the overall mean. And I have sort of have an error minimization rational statistically.

Male: But at the end of the day you lose the – I mean no matter what, you lose some of the ability to differentiate providers. I mean they essentially becomes wide confidence levels, right? I mean that's what you – the result of all that.

Male: Yes, if you're in a low information context where, you know, you only observe a small number of cases then that does limit your ability to make performance comparisons.

So what we tend to focus on is how much useful information remains even in a low information context and far from the case that even, you know, in a low information context. There's still a lot of useful information remaining. That is much as you might like, but it's still useful enough for consumers and providers to make informed decisions.

Male: I think my issue with this whole numbers is not to say that I understand what you're all saying about, about how you can utilize small numbers to – there's still some useful information remaining. As my point was how it relates the coding issue in that and that it doesn't take a lot of coding changes from one – coding differences and coding strategies from one provider to another when you have small numbers to make a difference.

I think that was my connections there. And that's the way the world is. I mean, you know, your (N) is low then a quest of coding can – is easier to make a difference, moving from one category to another. So, I worry about the usefulness of this measure in differentiating providers in the real world, in the practical real world. Because the assumption with the measures is, is that you have good codes and then people are coding the same way.

Male: And that's true for any …

Male: … to make it work.

Male: … coded measure.

Male: Yes.

Male: You're always …

Male: But as I say is that – that is amplified in a small number situation. It might (inaudible).

Male: I think, you know, a usual response and respect to the principal diagnosis, question is the one that was articulated earlier. There's always sort of a sensitivity specificity trade off with the respect to identifying patients, the GI (lead) in approach that is really applied to have consistently as you allude it to

sort of applied consistently across all the QIs is to focus more on the specificity than the sensitivity and focus on the cases where we have a greater degree of confidence with the conditions associated with GI hemorrhage. But by virtue of that, we're going to miss some cases that are also related to GI hemorrhage, but are (words) identified in the secondary codes.

Male: Right.

Male: You know, so it's a trade off. Absolutely.

Male: Any other comments for anybody regarding this measure? Is there any specific decision we need to come by or just …

Female: Just, just – anybody on the committee wish to revote the measure or not, same as the other. Legislates any further issues that you'll – make you want to revote.

Male: Is there any body on the committee that would like an opportunity for a revote? Or we – and it's not then that obviously the assumptions that were all OK with the votes that we have made, whatever that vote was?

Female: The original – I don't know what to recommend.

Male: I don't hear anyone speaking up, so I'm thinking the votes – the prior vote is a vote.

Female: Well, I think you have covered everything that what came up on the comments unless anybody wants to raise any other issues that haven't been discussed. If not, we can move forward to the member until the comment period.

Male: Hearing none, I think you can open it up for public comment, a member on public comment. I can't have the members as public as well. Who opens the lines just or …

Female: All right, just (test) for operator. (Nancy), you can open up the lines for public comment please.

Operator: Yes, all lines are open.

Female: Thank you.

(Tom James): Andy, this is (Tom James).

Andy Baskin: I'm sorry, well, I was on mute. Yes, hi, Tom, go ahead.

(Tom James): All right. Just a couple of things and I appreciate all of the efforts that the committee has put together. Number one is the movement towards ICD-10 and how that's going to impact, particularly the eMeasures, because I did not see ICD-10 coding put in there specifically.

But secondarily, and that gets to the larger measure – larger issue as you know last week in (JAMA), all right, Doctors (Coneway), (Clancy) and (Fasards) put together an article on the direction for measures and made specific comments that we should avoid small or, you know, avoid what they call narrow focused measures and think more in terms of national quality strategy. I'm concerned that a lot of the measures discussed today are still very much in that older mode of being narrow focused. They're important but they're – it's the context which counts.

Andy Baskin: Yes, I appreciate that (Tom). I'm going to ask someone to comment about ICD-10 because I believe that NQF already has them processed around the ICD-10 coding. Interesting about your other comment but I – and I also saw that article.

I think one of the issues is that, still, people need measures that will help them with quality improvement and oftentimes the broader measures on is specifically helpful for quality improvement but I think it's – and both stated by you and by many that there is a need for some additional measures that are broader and more encompassing type of measures that you speak about not necessarily to replace these measures but in potentially in addition to these measures.

(Tom James): Thank you.

Andy Baskin: Thanks, (Tom). But that comment about ICD-10, because I believe that's something that's in NQF documents already about …

(Crosstalk)

Reva Winkler: Yes, this is Reva. As of April 1st we're requiring the – both ICD-9 and ICD-10 with the major submissions. These measures preceded that requirement so we would anticipate however on their next annual updates that they will be submitting updates to include ICD-10 coding.

(Tom James): OK, good. And all the measure developers are going to be using the same GEMs format?

Reva Winkler: Their requirement is that they explained how they did their conversion and GEMs is certainly an option.

Andy Baskin: Thank you, Reva. Any other public member comments?

Perhaps we'll give another minute or so if someone wants to speak up gathering their thoughts.

Reva Winkler: Andy, I think those who wanted to speak have spoken.

Andy Baskin: Yes, it sounds that way. So, are we officially adjourning the meeting or is there anything else that needs to be said from NQF?

Reva Winkler: If there questions from any – Yes, any questions from any committee members? No. Suzanne, I'll let you know what the next steps are but thank you very much for your time. Suzanne?

Andy Baskin: Yes …

Suzanne Theberge: Yes, just to let you know the next steps. We're going to move these measure to NQF member voting so what we'll do is we'll write up responses to all the comments that don't already have a response and we'll redline the reports that was put out for comment and both – when both of us are ready we will open that for NQF member voting.

We're expecting to open that either Friday or Monday most likely and I will let the committee and the developers know when that's open and that lasts for two weeks and once that has closed the – we'll let you know the results and the measures will be brought to CSAC, the Consensus Standards Approval Committee for their review and we expect to – that to happen at their July meeting. I believe that's July 11th and 12th. Is that correct, Evan?

Evan Williamson: No, the 10th and 11th.

Suzanne Theberge: Oh sorry, 10th and 11th. So that will – Once we have that agenda finalized, I'll let you know when those measures will be discussed and following CSAC review their board – get their stamp of approval and that's the official enforcement date and then we'll have one more opportunity for people to weigh in and that's the appeals period which will open after the board endorsement.

So next steps are just – NQF staff working on the responses and getting everything ready for vote. This pretty much concludes most of the committee's work. We may ask you to weigh in on one of the responses – some of the responses just to make sure that we've added and requested everything but we don't anticipate that something major comes up. We don't anticipate any further conference calls or anything for the committee.

So we just want to say thank you very much for all your time. You have put in an enormous amount of time and effort on this project and I will be in touch by email but at this point pretty much all of your work is done on this project, so thank you.

Andy Baskin: And on behalf of Chris and I, thank you as well for your great preparation and participation especially today as well. Have a good one.

Reva Winkler: All right, thanks everybody for your time and have a good evening.

Suzanne Theberge: Thanks.

Reva Winkler: And at this time, this call is concluded.

END