

NATIONAL QUALITY FORUM

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HEALTH AND WELL BEING
STEERING COMMITTEE MEETING

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WEDNESDAY
April 30, 2014

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The Steering Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Thomas McInerney and Sarah Sampsel, Co-Chairs, presiding.

PRESENT:

THOMAS MCINERNEY, MD, Co-Chair

SARAH SAMPSEL, MD, Co-Chair

CHISARA ASOMUGHA, Centers for Medicare &
Medicaid Services

JOHN AUERBACH, Northeastern University

RON BIALEK, Public Health Foundation

JUAN EMILIO CARILLO, Weill Cornell Medical
College, NYP

JANE CHIANG, American Diabetes Association

ERIC FRANCE, Kaiser Permanente

RENEE FRAZIER, Healthy Memphis Common Table

RON INGE, Delta Dental of WA

DAVID KROL, Robert Wood Johnson Foundation

MARGARET LUCK, Mary's Center for Maternal &
Child Care

PATRICIA MCKANE, Michigan Department of
Community Health

AMY MINNICH, Geisinger Health System

JACQUELINE MOLINE, North Shore Long Island
Jewish Health System

MARCEL SALIVE, National Institute on Aging

KATIE SELLERS, Association of State and
Territorial Health Officials
JASON SPANGLER, Amgen, Inc.
MIKE STOTO, Georgetown University
ROBERT VALDEZ, Robert Wood Johnson
Foundation Center for Health Policy
ARJUN VENKATESH, Yale University School of
Medicine

NQF STAFF:

HELEN BURSTIN, Senior Vice President,
Performance Measurement
ADEELA KHAN, Project Manager, Performance
Measurement
ASHLEY MORSELL
ELISA MUNTHALI, Managing Director
KAITLYNN ROBINSON-ECTOR

ALSO PRESENT:

MARY BARTON, NCQA
SEPHEEN BYRON, NCQA
ROBYN NISHIMI, Healthcare Quality Consultant
PAMELA OWENS, AHRQ
PATRICK ROMANO, UC Davis, AHRQ*
CAROL STOCKS, AHRQ*

* present by teleconference

A-G-E-N-D-A

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1 P-R-O-C-E-E-D-I-N-G-S

2 9:07 a.m.

3 MS. MUNTHALI: Good morning again
4 and welcome to the Health and Well Being
5 Standing Committee meeting. This is day 2.
6 And I will turn it over to our co-chair
7 Sarah Sampsel.

8 But before we do that, Cathy, we
9 just wanted to make sure that Patrick Romano
10 from AHRQ is on the line.

11 OPERATOR: He has not joined yet.

12 MS. MUNTHALI: Okay. And that's
13 fine.

14 DR. SAMPSEL: Well, good morning,
15 everybody. And I guess another day in kind
16 of gloomy, rainy D.C. But I'll speak on
17 behalf of New Mexicans that it's really nice
18 to see rain. That stuff falling from the
19 sky.

20 Anyway, hope everybody had a great
21 dinner and a nice evening last night.

22 And we managed to get a lot done

1 yesterday. However, today we do still have
2 six measures. Five of those continuation of
3 our PQI or prevention quality indicator
4 discussion from AHRQ. And then an NCQA
5 breast cancer screening measure before we go
6 to some more general conversations about
7 measure gaps and next steps for this
8 committee.

9 But before we do that, just wanted
10 to ask if there were any additional process
11 questions, any reflections overnight that
12 anybody wanted to share with the committee
13 before we got started.

14 Hearing none and seemingly everybody
15 is awake we will go ahead and get started.
16 And our first measure this morning will be
17 0728, the asthma admission rate. In our PDF
18 of all of the comments that's page 43.

19 And to start out I will ask Pam if
20 she has any introductory comments or any
21 reflections from yesterday's discussion.

22 MS. OWENS: There's not a lot more

1 to say than what was said yesterday. All of
2 the measures that AHRQ is the steward for
3 are in the same vein as yesterday that we
4 talked about in terms of the overarching
5 prevention quality indicator.

6 The measure you voted on yesterday
7 was a pediatric measure. This is also a
8 pediatric measure. The rest of the measures
9 today are adult measures. So just making
10 sure you understand we're changing age
11 groups after this measure.

12 Again, the attribution is not
13 assigned and it is not intended to be to a
14 physician or to a hospital. It is a
15 healthcare system broadly defined and that
16 does include community factors.

17 And it's a way to drill down a
18 little bit further and say maybe this is an
19 area of emphasis or priority. I'm just
20 reflecting on that because of the way the
21 care setting statement probably from our
22 paper or from what we submitted, it seems to

1 be much more specific and just highlighting
2 ambulatory care, that's very broadly
3 defined. So I'm just highlighting that
4 piece for you.

5 All of it does use the healthcare
6 cost and utilization project data. I gave
7 you a little bit of description around
8 there. So other than that I think we're
9 ready.

10 DR. SAMPSEL: So, Amy, were you the
11 lead on this one? No? Was this changed?
12 Jacki and who? Okay, so Jacki, are you
13 prepared to lead us through this?

14 MS. MOLINE: I had my name next to
15 this one so I'm cool with this one.

16 (Laughter)

17 DR. SAMPSEL: All right, awesome.
18 Okay, gotcha.

19 MS. MOLINE: So, you don't get the
20 look of like a deer in the headlights like
21 yesterday.

22 This is an update of an outcome

1 measure that is looking at admission rates
2 for children age 2 through 17 for asthma.
3 And it is a, again, this is looking to see
4 whether improvement in the measure leads to
5 less hospitalizations with the thought that
6 it would be leading to better control and
7 better management in an outpatient setting
8 of an ambulatory-sensitive condition.

9 So, it was -- it's on a population
10 basis, county or city. And it uses hospital
11 data and administrative claims.

12 And I'm happy to go through the
13 evidence if we'd like, or if you'd like me
14 to do that.

15 Basically it's an avoidable
16 admission looking at the rates which have
17 been fairly stagnant. If you look at the
18 rates through 2007 to 2011 the rates have
19 basically not changed. There have been
20 little blips. There is a definite
21 difference between age grouping with the
22 younger children being admitted more, and a

1 definite men -- boys are -- there's a gender
2 disparity and there's also an income
3 disparity. There's also a regional
4 disparity which has not been well described
5 or well -- it wasn't really addressed at
6 all.

7 I mean, it's almost 3 to 1 from the
8 Northeast to the West, whether it's
9 environmental factors or other elements. I
10 can't believe that asthma rates are so
11 different. But that's what the data are.

12 And it's -- so that is basically --
13 there's definite room for improvement.
14 There has not been much improvement since
15 2007 when you're looking at the data.

16 And I think this is a health
17 priority. This is one of the leading causes
18 of preventable admissions in children and a
19 way of assessing whether better outpatient
20 control can lead to decreased admissions.

21 And it is a marker in many ways of
22 access to care and the overall ambulatory

1 health system. As well as what we discussed
2 yesterday with the social determinants of
3 health. Because it's such a multifactorial
4 issue. And obviously some children will
5 have greater severity of disease than others
6 that could lead to it.

7 So, that is basically the
8 introduction. I don't know, Margaret, if
9 there's anything you wanted to add or anyone
10 else?

11 MS. LUCK: Just to point out that
12 during the committee call a lot of the
13 issues we discussed yesterday about what's
14 the utility of this measure, to what extent
15 would changes in this measure reflect
16 changes in the outpatient care system versus
17 environmental changes. All of those issues
18 were brought up in the committee call. But
19 I think we talked about them.

20 MS. MOLINE: And the interesting
21 thing about this measure for me was when you
22 compare it to the gastroenteritis in

1 children is there was a tremendous drop-off
2 about two years ago in the gastroenteritis
3 admissions. And so the question was was
4 that related either to the vaccination or
5 was that related to differential coding
6 because people were in a holding area in an
7 ER. And so that they wouldn't actually be
8 admitted.

9 This one there's no difference in
10 their admission rates. So the severity of
11 necessitating an actual admission has not
12 changed and there is tremendous room for
13 improvement.

14 MR. AUERBACH: So, I hope this
15 doesn't feel like beating a dead horse, but
16 I do think this is one where it really does
17 make sense to say that the language I think
18 in the proposal that refers to this is
19 related to ambulatory care primarily is just
20 wrong.

21 I think the data are really strong
22 that asthma, that hospitalizations for

1 asthma among children is really primarily
2 caused by environmental factors. And good
3 care helps but it's primarily caused by
4 environmental factors. I think the data are
5 pretty clear about that.

6 And so I just think that in
7 approving it, if we're going to be voting on
8 approving it, the language just really
9 should change. I would recommend that we
10 ask for language that reflects that, that
11 the science is pretty clear on this.

12 For instance, we don't know what
13 causes asthma. We do know what causes
14 asthma triggers and hospitalizations. And
15 those are really things like, you know,
16 exposure to mold and mildew in housing,
17 dust, you know, roaches, pesticide exposure.

18 And really we've seen very effective
19 interventions at the community level not
20 related to care that have sharply dropped
21 the severity of asthma cases that results in
22 hospitalizations. So, just I do think the

1 language does matter a lot here.

2 DR. SAMPSEL: Okay. So I have Mike
3 and then Ron and then Patricia.

4 MR. STOTO: Pretty much along the
5 same lines. I'm looking at the rationale
6 1(b)(1) here. And I think that if you read
7 that having heard our conversation yesterday
8 and today you could see the right answer in
9 there. But you could also read that and not
10 understand that at all.

11 So I think that really is the place
12 where a more careful explanation of the kind
13 of things that John was just saying would be
14 helpful. So it's an editorial comment
15 rather than a comment about the measure
16 itself.

17 MR. BIALEK: Yes, as a community
18 measure I think it's a very, very strong
19 measure where at the community level some
20 action can be taken to make a difference.

21 The question I have pertains back to
22 the stratification issue I mentioned

1 yesterday. Can -- well, with this
2 particular measure where we're not making
3 progress, where disparities could actually
4 be widening and could be hidden in the data
5 if one does not stratify, can we actually
6 have a measure that specifies the measure is
7 meant to be stratified in certain ways.

8 And the reason again I ask that is
9 if we are looking for improvement to occur
10 at the community level I don't think it
11 really will occur unless we do have the
12 stratification if that's part of the
13 measure. If we just adopt the measure the
14 way it is I think we could see the
15 disparities grow.

16 MS. MCKANE: I guess I look at it
17 just a little bit differently. And I
18 understand the causal pathway is not all
19 that well know. We know the triggers and we
20 know the environmental factors.

21 But is this a measure of -- is it
22 also a measure of how well controlled asthma

1 is to prevent hospitalizations?

2 I know, I've worked more with asthma
3 epis trying to understand the rationale
4 behind the emergency department metric for
5 unmanaged asthma or poorly controlled
6 asthma. And is this an extension or another
7 way of trying to get at that is how well
8 controlled the asthma is? Which is a
9 reflection of -- as more broad factors than
10 just care, but access to care and other
11 factors.

12 MS. OWENS: So I don't quite
13 understand the question other than I hear
14 where you're going a little bit in terms of
15 from an ED perspective versus an inpatient
16 perspective.

17 This is an inpatient measure in
18 terms of we are capturing those cases that
19 resulted in an inpatient hospitalization.
20 Meaning they're severe enough to require an
21 overnight stay.

22 There are lots of places that that

1 overnight stay could be prevented from both
2 a care perspective but from a patient
3 compliance with their preventive medication,
4 with your environment, with actual social
5 determinants of health, with health
6 education. There's many places that that
7 hospitalization could have been prevented.

8 Now, on the ED portion of it you
9 could debate and I think Dr. McInerney
10 brought this up which is maybe the ED is the
11 appropriate place for treatment.

12 And that's not at all what this
13 measure is getting at. This measure is
14 these asthmatics are severe enough, or this
15 case of asthma is severe enough that it
16 required a hospitalization that could have
17 been prevented had a number of other factors
18 been in place.

19 So I'm not sure I understand your
20 question.

21 MS. MCKANE: Well, I was just trying
22 to get at that there were other, you know,

1 you're talking about environmental and
2 community factors, and that maybe this
3 measure should be changed. And I was trying
4 to counter that a little bit with the fact
5 that maybe it shouldn't simply because it is
6 getting at other factors or other -- you
7 know, it may be a reflection of care.

8 I guess, I mean you're saying these
9 are admissions that could have been
10 prevented. Are you assessing that through
11 coding as to what could have been prevented
12 and what couldn't have been prevented?

13 MS. OWENS: In terms of whether or
14 not they could or couldn't be prevented and
15 coming up with a proportion that could be
16 prevented I'd have to go to the literature
17 for that.

18 I do know that the literature
19 strongly suggests that there are lots of
20 ways of preventing asthma admissions. So, I
21 think in the measure testing form hopefully
22 one of those tables talked about

1 preventability. If not, I have a different
2 analytic template that I could tell you
3 preventability which gets at some of that
4 and that's through modeling.

5 But again, you know, you have to
6 look at the individual case. So I'm not --
7 that's a modeling exercise to come up with
8 preventability. Other than to say the
9 literature all points to asthma admissions
10 are preventable.

11 DR. SAMPSEL: So we're going to go
12 Arjun, Emilio and then Ron.

13 MR. VENKATESH: So, I think this is
14 a good measure and I think we're almost
15 beating up on it too much. Because asthma
16 as a space over the last 10 to 20 years has
17 had so much investigation and research in
18 comparison to a lot of these other areas
19 that we would think about these PQI
20 measures.

21 To me the things that stick out are
22 there's almost no other PQI measure where

1 there's a link between community changes
2 that can be made and the outcome measure as
3 well as health system process of care
4 measures that can be made and the outcome
5 measure.

6 And so here's a place where both at
7 the community level and processes of
8 clinical care can both impact the outcome.

9 The fact that we're going to capture
10 social determinants of health in the outcome
11 to me doesn't bother me that much. And the
12 reason is that of the 600-odd NQF measures
13 that are endorsed you have your like, say,
14 60 or so that are outcome measures. They
15 are all impacted by social determinants of
16 health.

17 And I think this is the choir in
18 this room that recognizes that. And we'll
19 be clear in the report when we say that,
20 that the measure is not specified to be at
21 anything but a community level. And so to
22 include social determinants of health as

1 well as those health system and clinical
2 processes in that is totally okay. And each
3 community can use it in the way that they
4 need to use it.

5 And here's a place where, like I
6 said, the linkage between the process and
7 outcome is really good at two levels. And I
8 think that it's actually easy to get past
9 kind of question 1 here, more so than other
10 measures.

11 For what Pam was just alluding to
12 regarding the denominator being
13 hospitalizations and not ED visits, I think
14 that relates to a lot of these measures.
15 Not so much here.

16 I think that there is enough
17 literature to suggest that when you have
18 inpatient hospitalizations for asthma that
19 better outpatient care can reduce full
20 hospitalizations as well as ED visits --
21 that's a separate issue -- and that
22 community changes can reduce inpatient

1 hospitalization.

2 So I'm actually okay with this
3 denominator here unlike some of the other
4 measures where I think a different
5 denominator would be better.

6 MR. CARILLO: Yes, I want to echo
7 some of what's been said and just add
8 perspective.

9 There's a lot of evidence that's
10 accumulated in the last 20 years that the
11 neighborhood effect, that there's a
12 compounding of social determinants by
13 neighborhood, not by county, not by large
14 MSA which drive a lot of health outcomes.

15 I think that we all are saying that
16 there is significant confounding in terms of
17 the social determinants for this and other
18 related measures. So I think that has to be
19 stated.

20 I'm not talking about a black box
21 warning, but it has to be stated in a way
22 that the public, the press and others who

1 may refer to this measure for whatever
2 endpoint they may have that that be put into
3 a highlight.

4 The other thing, I think there's
5 another level of confounding which is the
6 MSA. I mean, just what I best know, New
7 York City, Manhattan is a county. New York
8 County. And you have East Harlem which is
9 close to particularly environmental exposure
10 just like the South Bronx just opposite the
11 Harlem River where you've had historically
12 very high rates of asthma.

13 And then you have other
14 neighborhoods further down south like the
15 Upper East Side where the levels are quite
16 low. So, I think that if you provide a
17 measure at a county level you're totally
18 going to miss the fine point.

19 And true, it's a good measure, it
20 says a lot, but it has to be qualified in
21 the language that we put forth.

22 MR. BIALEK: Arjun, I don't think I

1 hear anybody disagreeing with the measure.
2 I think it's how it's specified. And then
3 also the point I tried to make was about the
4 stratification piece similar to what you
5 were just saying is that without that being
6 specified in the measure I don't think the
7 measure -- it could actually have an adverse
8 impact and that's what concerns me.

9 MS. SELLERS: So, I guess my comment
10 is more of a technical question which has to
11 do with from the measure information form
12 that we have, you know, what language from
13 that goes directly into the NQF report
14 versus what might need to be changed.

15 So, if there's language in here
16 under the developer rationale that very
17 clearly talks about this being a function of
18 the healthcare as opposed to the more
19 environmental factors is there a process to
20 change that? Or does that get changed just
21 because we're having this conversation?

22 MS. SELLERS: I'll answer that. So

1 we don't change the specifications. We
2 include the specifications as part of the
3 report.

4 But because this is an important
5 issue we'll make sure that -- I think, Pam,
6 in the submission that you sent to us this
7 is causing quite a bit of confusion. So
8 this might be something that we may ask the
9 developer to change to make it a lot more
10 clear.

11 Because even if in our narrative of
12 the discussion that you're having we specify
13 it as you would like there would be a
14 discrepancy between what's in the submission
15 and what we put in the report.

16 And so I think the committee can
17 make a recommendation to the developer to
18 say, to make it clear to change that
19 language in there.

20 MS. OWENS: And I'm perfectly, I
21 think it's great. I actually am an
22 asthmatic and have been for 44 years so I

1 understand all of these factors and where
2 you're coming from and I don't think it's a
3 function of the healthcare system entirely.
4 That being said, it's all in perspective.

5 So, I from my hat, I see what people
6 download on the AHRQ website. I know who I
7 talk to. I know how we talk about this
8 measure. And we talk about it in this
9 broader context.

10 I actually -- this form to me was
11 just a conduit to get information to you and
12 I didn't think it went anywhere other than
13 you all.

14 Now, that being said, I totally
15 agree with you it does not reflect my
16 thinking, does not reflect AHRQ's thinking
17 and from a record standpoint absolutely
18 needs to be corrected.

19 So, again, I don't want you to feel
20 like that because this form says that it
21 either reflects AHRQ's thinking or that I
22 took this to be anything more than quickly

1 trying to share with you eight measures in
2 a period of 48 hours to get the forms
3 together.

4 MR. VALDEZ: All right, I'll take
5 some of the blame for the interpretation.

6 Those of us who started using this
7 measure in the early and mid-eighties in New
8 York City and Los Angeles County were in
9 fact interested in looking at the primary
10 care delivery system and had to come up with
11 some way of beginning to look at this.

12 And our initial interpretations were
13 trying to find ways in fact that affected,
14 or that were being affected by the lack of
15 primary care in those communities.

16 And this is just reflecting
17 historical development of something that has
18 grown to a much bigger understanding, that
19 in fact a number of these conditions in fact
20 have both medical components and a community
21 component. And you know, some of the
22 historical initial development stuff has to

1 be corrected with our better understanding
2 of how each of these individual measures
3 operate.

4 DR. SAMPSEL: Okay. So, I think if
5 there's nothing else on that first section
6 we will go ahead and ask Kaitlynn to start
7 the vote. And we'll start with the evidence
8 and section 1.

9 Does everybody have their fun little
10 voting things? Excellent.

11 MS. ROBINSON-ECTOR: For evidence
12 the vote is open. We're waiting on one more
13 vote.

14 MS. MUNTHALI: Michael Baer will not
15 be here today.

16 MS. ROBINSON-ECTOR: Okay, so then
17 we have all of the votes in. Okay, for
18 evidence we had 20 vote yes and zero vote
19 no.

20 For performance gap the vote is
21 open. All of the votes are in. Voting is
22 now closed. For performance gap 17 voted

1 high, 3 voted moderate, zero voted low and
2 zero voted insufficient.

3 For high priority the vote is now
4 open. All of the votes are in and voting is
5 now closed. For high priority 20 voted
6 high, zero voted moderate, zero voted low
7 and zero voted insufficient.

8 DR. SAMPSEL: Okay, Jacki, do you
9 want to introduce this section and we'll
10 open for discussion?

11 MS. MOLINE: Sure. So in terms of
12 reliability this is -- the numerator is
13 discharges for patients 2 through 17 with an
14 ICD-9 code for asthma. The time window is a
15 year. This excluded children with other
16 conditiosn that might have pulmonary
17 complications.

18 And the denominator was discharges -
19 - the denominator is -- it's discharges from
20 the hospital. The denominator is only
21 within the asthmatic population. The only
22 issue is that they had to have a preexisting

1 diagnosis of asthma and be coded as such at
2 the time of admission for them to be in the
3 denominator. But it's all based on
4 hospital-based data.

5 MS. ASOMUGHA: So, do the diagnoses
6 or the patients, this is including folks who
7 have actually died after admission for
8 asthma?

9 MS. MOLINE: They would have had a
10 discharge diagnosis of asthma death. Oh,
11 yes.

12 DR. SAMPSEL: Margaret?

13 MS. LUCK: So I think this is
14 similar to the measure we talked about
15 yesterday afternoon where the numerator is
16 the discharges of patients from a certain
17 metropolitan area. And the denominator is
18 the total population in that age group in
19 that metropolitan area.

20 DR. SAMPSEL: Other comments,
21 concerns, questions about reliability and
22 overall scientific acceptability before we

1 vote? Okay, Kaitlynn? Oh, I'm sorry, John?

2 MR. AUERBACH: I guess I just wonder
3 if AHRQ has any explanation for the regional
4 disparities. What's going on in the West
5 that seems to be so much better?

6 MS. OWENS: Well, there is something
7 to be said for the environment in the West.
8 I mean, people have been known to move to
9 Arizona and New Mexico who are asthmatics.

10 The urbanicity. Actually some of
11 the issues that come up in New York City are
12 not as prevalent although we do have
13 obviously large urban areas in the West.
14 But how many large urban areas in the West
15 do we have relative to the Northeast. So I
16 think there's some environmental factors
17 coming into play.

18 And I think basically you would need
19 to look at the regional aspects combined
20 with the environmental aspects. And in
21 fact, CDC is looking at this issue with
22 respect to weather changes, you know, the

1 environment at large. So I think there's
2 quite a bit that might really actually
3 account for the regional variation.

4 MR. ROMANO: And if I might add
5 something.

6 MS. OWENS: Wonderful, Patrick.
7 Glad you joined us. Good morning.

8 MR. ROMANO: Good morning. Yes, I
9 was also going to say that there's a general
10 pattern of practice differences.

11 So, even if you look at overall
12 measures of hospital discharges per capita
13 they're lower in the western United States
14 than in the eastern United States.

15 And this is perhaps partially due to
16 differences in training, differences in
17 practice.

18 It may also reflect the higher
19 penetration of large managed care
20 organizations such as Group Health and
21 Kaiser Permanente in the west coast states.

22 And of course some of those managed

1 care organizations that are closely aligned
2 with medical groups have implemented
3 aggressive programs to keep patients out of
4 the hospital through better primary care
5 management of chronic diseases.

6 So there's a variety of potential
7 explanations. But this is an ongoing
8 phenomenon that's been observed for a couple
9 of decades.

10 DR. SAMPSEL: Okay. I don't see any
11 other questions or comments, so Kaitlynn?

12 MS. ROBINSON-ECTOR: This is for
13 reliability and the vote is open. All of
14 the votes are in and voting is now closed.

15 For reliability 18 voted high, 2
16 voted moderate, zero voted low and zero
17 voted insufficient.

18 DR. SAMPSEL: And any comments,
19 concerns about validity? Jacki, did you
20 have some comments?

21 MS. MOLINE: No, I think the
22 measures are valid. They're using

1 standardly accepted discharge data.

2 DR. SAMPSEL: And discussion on
3 validity of the measure.

4 MR. FRANCE: Since we have our
5 experts here I'd like to hear more about the
6 construct validity testing that you've done
7 for these ACSC measures in general where you
8 have these models that try and demonstrate
9 that the rates of these events are aligned
10 with things that are thought to demonstrate
11 the health system's infrastructure.

12 MS. OWENS: Patrick, do you want to
13 talk about why these models were selected
14 for validity? Patrick, are you on mute?

15 MR. ROMANO: Yes, I was, thank you.
16 Yes, if you could give me a second to pull
17 up the results table.

18 MS. BURSTIN: Patrick's in
19 California so it's 6:30 in the morning for
20 him.

21 MS. OWENS: So Patrick, this was the
22 table, and correct me if I'm wrong, that

1 you're speaking of in terms of the volume,
2 the reservation quality, the model that was
3 provided.

4 MR. FRANCE: I think it was a model
5 that looked at density of physicians,
6 insurance coverage, beds available and it
7 was posed as a demonstration of the
8 construct validity of the metrics as being
9 aligned with health infrastructure,
10 healthcare delivery infrastructure systems.

11 And since it plays out with all
12 these ACSC measures we'll be talking about
13 today I thought it would be helpful to hear
14 a bit more about that model since it's the
15 key piece that seems to argue that these
16 measures are indeed reflective of the
17 healthcare infrastructure.

18 MR. SPANGLER: It's table 3 in the
19 testing form. I think it's page 7 of 12.

20 MS. OWENS: The reason I'm letting
21 Patrick answer this is because as part --
22 under the previous contract they're the ones

1 that made some decisions about why these
2 models were developed in particular. I can
3 speak to them after Patrick if need be. I
4 have a sense of why they were chosen.

5 MR. ROMANO: Right, okay. Thank you
6 for cluing me into the location of what
7 you're looking at.

8 So, the notion is that these
9 measures obtain their construct validity in
10 part from their relationship to primary care
11 resources that are available in local
12 communities.

13 So, we would anticipate that if an
14 area has greater availability of physicians,
15 particularly I should add a greater
16 availability of primary care physicians
17 which unfortunately is not tested here, then
18 the hospitalization rates for the condition
19 should be lower.

20 On the other hand, if there's excess
21 capacity in terms of having a relative
22 excess of beds those beds may be utilized,

1 there may be more of an incentive to fill
2 those beds by increasing hospitalization
3 rate.

4 The poverty status and insurance
5 status are of course markers of SES as we've
6 discussed.

7 I think population density is
8 difficult to interpret. In some cases it's
9 a marker of urbanity and therefore it may be
10 a marker of geographic proximity to
11 services. In other areas it may be a marker
12 of poverty or over-population and therefore
13 more limited access to services or
14 constraint in supply. So, after adjusting
15 for other factors.

16 So, in this case and in most cases
17 there is a significant association between
18 the F1 variable which represents physician
19 supply and the outcome variable.

20 The prior performance is a marker of
21 the same area's rate in the previous time
22 period. So not surprisingly there is

1 substantial consistency over time in area
2 level rate and that's reflected in the lower
3 half of table 4 with the high-parameter
4 estimate of 0.72.

5 So basically what that is telling
6 you is the single strongest predictor of the
7 current rate in an area is the prior
8 period's rate in the same area.

9 After adjusting for prior
10 performance the impact of physician
11 population ratio diminishes. That's
12 reflected in the two estimates of F1
13 dropping from a statistically significant
14 estimate in the first half of the table to a
15 non-significant estimate in the second half
16 of the table.

17 Does that explain the situation?

18 MR. FRANCE: It does. I think it
19 was more the high-level conversation about
20 these measures themselves.

21 It looks like you create an overall
22 F1 construct variable and then an F2

1 construct variable between high-quality
2 outpatient care and then market competition.
3 And then put those in the model and look at
4 their impact.

5 So, given in general that some of
6 the construct validity of the measures are
7 based on these models I just wanted to hear
8 a little bit more about them. And why you
9 chose these variables, and how confident you
10 are that they're indeed reflecting of the
11 care delivery programs that are in place.

12 MS. OWENS: And so these --

13 MR. ROMANO: Yes --

14 MS. OWENS: Go ahead, Patrick.

15 MR. ROMANO: I was going to say yes.
16 I mean, thank you for the opportunity to
17 explain it. I have to admit it is a little
18 bit obscure.

19 And because of the way -- what
20 unfortunately I don't think we provided here
21 was a clear explanation of the F1 and F2
22 construct. So, that's missing, so I

1 apologize for that.

2 MS. OWENS: So, F1 and F2 constructs
3 are derived from the area resource file.
4 And the area resource file is at the county
5 level. And that's how we could do this.

6 I will have to go back to --
7 Battelle is the contractor that actually ran
8 these models and created these constructs.
9 Patrick is actually at UC-Davis. He's not
10 with Battelle.

11 So, for additional explanation in
12 terms of the forms I think it would be
13 worthy, exactly what Patrick is talking
14 about, is how were these constructs derived
15 specifically. That would just give you --
16 you understand the concept. But if you want
17 to know analytically how they were derived I
18 can get that information.

19 Battelle is no longer the AHRQ QI
20 contractor.

21 DR. SAMPSEL: Jason.

22 MR. SPANGLER: So, I have a question

1 specifically about this measure and this
2 construct. The coefficient was much less in
3 this one compared to the other measures
4 we're going to be looking at including the
5 one yesterday.

6 And is that reflective of -- that
7 these variables within this construct have
8 less of an impact on this measure? Going
9 along with what we've talked about, the
10 environmental factors and other factors,
11 other variables that aren't in this
12 construct. Is that the explanation for
13 that? Or is there any other explanation?

14 Because this coefficient is in the
15 0.7 and change range where the other ones
16 are like 0.9, low 0.9, 0.8. So I'm just
17 wondering if that's the explanation, or are
18 there other explanations for that.

19 MS. OWENS: You're speaking of the
20 prior performance?

21 MR. SPANGLER: Yes.

22 MS. OWENS: I would explain it as

1 prior performance plays a huge role in all
2 of the measures. Yes, for the asthma
3 measure. Less so if it's relative to some
4 of these other factors.

5 DR. SAMPSEL: Okay. I believe we're
6 ready for a vote on validity.

7 MS. ROBINSON-ECTOR: This is
8 validity and voting is now open. All the
9 votes are in and voting is now closed. For
10 validity 10 voted high, 10 voted moderate,
11 zero voted low and zero voted insufficient.

12 MS. MOLINE: So the feasibility of
13 this. It's very feasible. It's readily
14 available data sources. And it is using
15 hospital discharge data. So the group felt
16 that it was a very feasible measure.

17 DR. SAMPSEL: Any discussion on
18 feasibility? Okay, Kaitlynn.

19 MS. ROBINSON-ECTOR: For feasibility
20 the voting is now open. All the votes are
21 in and voting is now closed. For
22 feasibility 19 voted high, 1 voted moderate,

1 zero voted low and zero voted insufficient.

2 MS. MOLINE: So in terms of
3 usability and use I think this is a measure
4 that is being used as was pointed out and
5 has been used for 20 years now. I think
6 that there are some areas where zip code
7 level data are available and it is being
8 used.

9 But on a macro level, looking at it
10 at a county and in urban, rural parts of the
11 country versus other parts of the country it
12 is a usable measure and is -- there were no
13 issues related to that. And it was
14 something that could be easily tracked over
15 time.

16 It was noted that there are many
17 factors out of the control of the hospital.
18 And the environmental issues. And the
19 regional disparities.

20 There was some concern about the
21 flatness of the measure. But overall it was
22 felt to be a usable, highly usable measure.

1 DR. SAMPSEL: Any discussion on
2 usability?

3 MR. BIALEK: Yes, I'd like to go
4 back to the concern I raised before. If one
5 looks at 4(c) benefits outweigh evidence of
6 unintended negative consequences. I think
7 there can be negative consequences.

8 And yes, the measure is being used,
9 but we're not making progress. So I
10 question if the measure is specified
11 correctly for what it is we're trying to
12 achieve.

13 And again, I would go down to the
14 need to further -- the measure should
15 specify it needs to be stratified in certain
16 ways.

17 DR. SAMPSEL: All right, Kaitlynn.

18 MS. ROBINSON-ECTOR: For usability
19 and use and the voting is now open. We're
20 just waiting on one vote. All the votes are
21 in and voting is now closed.

22 For usability, 12 voted high, 7

1 voted moderate, 1 voted low and zero voted
2 insufficient information.

3 MS. LUCK: I would just like to ask
4 if the developer could update some of the
5 references in the measure information form.
6 I noted that in one section the most recent
7 reference is 2009. In another it's 2008.
8 When I think how much work has been done in
9 this area.

10 DR. SAMPSEL: Okay, so before we go
11 to the overall suitability for endorsement I
12 think, Pam, you've probably taken a few
13 notes.

14 So, just to make sure that the
15 committee has been heard and they will also
16 be reflected in the overall notes on the
17 measure. But any other final comments,
18 considerations, discussion items before
19 suitability for endorsement?

20 Okay, Kaitlynn.

21 MS. ROBINSON-ECTOR: This is for all
22 suitability for endorsement. Voting is now

1 open. We're just waiting on one more vote.

2 All the votes are in and voting is
3 now closed. For overall suitability for
4 endorsement 19 voted yes and 1 voted no.
5 So, for measure 0728 Asthma Admission Rate
6 PDI 14 passes.

7 DR. SAMPSEL: Renee?

8 MS. FRAZIER: I just want to make
9 sure from a process standpoint. There were
10 a lot of great comments made. And I voted
11 in the notion that much of that will be
12 included in the conversation. I just want
13 to make very clear. Okay.

14 DR. SAMPSEL: Okay, so we're now
15 going to move to the front of the workgroup
16 summary PDF and start with -- actually,
17 still the PQI measures and this time start
18 working through some of the diabetes
19 measures.

20 And the first one is 0272 Diabetes
21 Short-term Complications. And we'll start
22 with comments from Pam or Patrick.

1 MS. OWENS: So, diabetes is the
2 leading cause of hospitalization and at
3 considerable cost. Over \$174 billion
4 annually are spent on diabetic
5 hospitalization. And the diabetes epidemic
6 continues to rise.

7 There is evidence that complications
8 can be prevented with appropriate management
9 in primary care.

10 The next four indicators you'll be
11 reviewing are all related to diabetes. Two
12 are short-term complications, two could be
13 considered long-term complications.

14 I think it was brought up in the
15 workgroup and I just want to highlight that
16 AHRQ is actually considering some of the
17 workgroup's suggestions, although of course
18 it would not have been for this submission
19 because it came up in the workgroup.

20 Anyway, so PQI 1 which is the first
21 one, the short-term complications. And then
22 PQI 14, making sure I get the name right,

1 the uncontrolled diabetes admission rate
2 could be combined. And we do recommend --
3 in the assessment you'll see that we
4 recommend that they're reported together or
5 paired so that you get the complete picture
6 in terms of admission rate.

7 And this was again brought up in the
8 workgroup is if you combined PQI 3 and PQI
9 16 which are the long-term complications
10 that those could be combined in a composite.

11 So, while that is not actually
12 what's on the table with respect to
13 endorsement I just wanted to let you know
14 that I heard what you said in the
15 workgroups. We are actively thinking about
16 that. But what you are considering today is
17 each of these indicators individually
18 because that's as it was endorsed initially.

19 Are there any other questions?
20 Patrick, did you want to add?

21 MR. ROMANO: Well, I can just add
22 that I found the technical report related to

1 the construction of the construct variables
2 if the committee would like more
3 information.

4 MS. OWENS: Thank you.

5 MR. ROMANO: Right. So, those
6 construct variables were constructed by
7 factor analysis. And it's a principal
8 factors unrotated method.

9 The F1 factor is essentially
10 dominated by physician density per capita.
11 Again, I think other researchers have used
12 primary care physician density per capita
13 and had actually found stronger results.
14 But there's a negative loading of physician
15 density and there's a positive loading of
16 hospitals that supply per capita which fits
17 with the hypothesized framework that having
18 excess hospital beds in an area will tend to
19 lead to more admissions. Having fewer
20 physicians per capita in an area will tend
21 to lead to fewer admissions.

22 In addition, there is a loading on

1 poverty which is consistent with the
2 socioeconomic issues that we've previously
3 discussed. The loading of population
4 density is mildly negative, but smaller than
5 the loading of physician density, 0.45
6 versus 0.25 negative, indicating that people
7 living in more densely populated urban areas
8 have better geographic access to primary
9 care resources, urgent care centers, other
10 facilities that may help to keep them out of
11 the hospital.

12 So that's the construction of the
13 factors. So factor 1 as I mentioned is
14 dominated by physician density with the
15 negative loading hospital density, with a
16 positive loading.

17 Factor 2 is a weaker factor that
18 basically has the inverse relationship but
19 it's dominated more by socioeconomic
20 factors.

21 DR. SAMPSEL: Okay, thank you,
22 Patrick. I will now ask I believe John and

1 Jane were the reviewers. And John, did you
2 want to lead the discussion for this
3 measure? Okay.

4 MR. AUERBACH: Jane and I will do it
5 together. But I'm happy to do that. I'm
6 sitting next to an endocrinologist. I think
7 there are many tabs I will defer to her.

8 But yes, you know, the discussion so
9 far I think has highlighted the main points.
10 The data source here is the administrative
11 hospital discharge claims. It's been --
12 this is a review of a measure that was
13 originally approved in 2007. It's been in
14 widespread use. And the level of analysis
15 is at the county, city, state, or national
16 levels.

17 DR. SAMPSEL: Were there any
18 comments, discussion on the workgroup about
19 evidence?

20 MR. AUERBACH: Well, I would say
21 here, I do think there what we know about
22 diabetes, type 2 diabetes, not type 1

1 diabetes, is that it is a disease that the
2 prevalence of which has been on the increase
3 since the nineteen eighties in a steady and
4 consistent manner.

5 And that it's correlated -- we know
6 what it's correlated with. It's correlated
7 with eating habits and lack of exercise.
8 And so it is an illness that is -- type 2 is
9 largely at the level of prevalence now
10 because of behavior factors and
11 environmental conditions.

12 So, I think like our earlier
13 discussion causation here is due to --
14 causation of type 2 diabetes is not due to
15 poor healthcare delivery, it's due to
16 environmental factors and conditions and
17 that's worth noting. So treatment of
18 existing diabetes for reduction of symptoms
19 avoids some hospitalization, definitely
20 benefits from access to high-quality care.
21 But around the issue of causation and the
22 fact that we've got rising hospitalizations,

1 that -- the background noise there is
2 related to the obesity epidemic. So it's
3 just worth noting because there are from the
4 perspective of approaches that can be taken
5 to reduce hospitalization it's another one
6 of these set factors where social
7 determinants are an important consideration.

8 MS. CHIANG: John, can I -- so first
9 of all, I want to apologize because I
10 actually missed the working group calls. I
11 actually -- I'm fairly new so I attended the
12 dental calls because I thought that was my
13 working group.

14 So there's a couple of things that -
15 - so I'm kind of starting from the
16 beginning. And I had a couple of questions
17 for you about the measures. Because the
18 short-term complications, while diagnostic
19 ketoacidosis is part of it the main reason
20 why people are hospitalized are due to
21 hypoglycemia and hypoglycemic seizures. So
22 I was wondering why that wasn't captured.

1 And it's particularly true in older people.

2 And John, I hate to do this but one
3 of the things that we really want to dispel
4 is the notion that type 2 diabetes is caused
5 by behavioral issues.

6 We don't know exactly why there's
7 this increased rise. We assume it is
8 parallel to the obesity epidemic. But we
9 don't think that's the only cause. There's
10 social determinants. There's epigenetics.
11 There's other reasons for this that we
12 haven't really understood. So I do want to
13 say that yes, that's part of it, but that's
14 not the sole factor.

15 And we really are trying to de-
16 emphasize that because then otherwise if
17 you're hospitalized for all the short-term
18 complications of diabetes it is a less
19 reimbursable item because it's tied to
20 behavior. And we don't want that to be the
21 message. Is that a fair assessment?

22 So that's something that I also want

1 to capture in part of this discussion.

2 MS. OWENS: Can I have Patrick
3 respond to that in terms of -- Patrick?

4 MR. ROMANO: Yes, I'm just double-
5 checking the specification. I'm not sure
6 that I'm understanding your question about
7 the hypoglycemia.

8 DR. SCHREIBER: So I think since he
9 missed the call I think I'll recap what I
10 heard Patrick say on the call which was
11 these are a family of measures.

12 And so you have all -- in the end
13 you have all the hospitalizations for
14 diabetes kind of parsed out in these next
15 four measures. And so hypoglycemia I think
16 would fall into the one that I have which is
17 number PQI 14 which would be -- because it
18 wouldn't fall under the other ones. So, it
19 would fall under uncontrolled diabetes
20 admission, none of the above.

21 And I heard this in the call that
22 there is some misclassification in these

1 measures because of that. So, it's based on
2 what people are admitted for.

3 But the general thrust and rationale
4 that I heard and which I believe is true is
5 just that -- is what John I think said but
6 very kind of glossed over it is, you know,
7 diabetes if it's recognized and managed can
8 be managed as an outpatient pretty much by
9 and large. And the hospitalizations can be
10 prevented.

11 And so these are outcome measures
12 with a rationale. And that's the rationale
13 that I heard. And I think it's true mostly.
14 You know, not 100 percent true, but true
15 enough for a measure or a set of measures.

16 So this one is on ketoacidosis,
17 hyperosmolarity or coma. Certainly those
18 are preventable almost completely if it's
19 recognized and not sprung on inadvertently
20 with some other acute event that occurs in
21 the patient.

22 So, I think that's the rationale for

1 this measure. And then the other measures
2 have sort of specific rationales that they
3 have.

4 MS. CHIANG: So thank you, Marcel.
5 I agree with you and I agree that this is
6 preventable.

7 MR. ROMANO: And just to clarify if
8 I might. So the 250.0 codes here are
9 referring to diabetic ketoacidosis. I'm
10 sorry, the 250.1 codes refers to diabetic
11 ketoacidosis.

12 The 250.2 codes refer to
13 hyperosmolar state and the 250.3 codes refer
14 to other diabetic coma. And most of that is
15 hypoglycemic coma or insulin coma. So these
16 are the most severe short-term
17 complications.

18 And I think it is true that among
19 type 2 diabetics most disease are related to
20 insulin excess rather than to ketoacidosis.
21 But there is a mixture of hyperglycemic and
22 hypoglycemic complications within this

1 indicator.

2 What's shared is that these are the
3 most serious of the complications where
4 there's actually -- in the case of
5 hypoglycemia there's hypoglycemic coma or
6 hypoglycemic shock. Those are the terms
7 that are typically used.

8 MS. CHIANG: So Patrick, are you
9 distinguishing between type 1 and type 2?
10 Or is this for all people with diabetes?

11 MR. ROMANO: No. These indicators
12 do not distinguish between type 1 and type
13 2.

14 DR. SAMPSEL: John?

15 MR. AUERBACH: So again, one thing I
16 would highlight here that I think is
17 particularly noteworthy in terms of looking
18 at the data are that we're seeing a very
19 dramatic increase in terms of
20 hospitalization for this measure. We're
21 seeing an increase of something like in 5
22 years 110,000 to 150,000 hospitalizations.

1 So really rapid year to year dramatic
2 increases.

3 And I guess I just would -- maybe I
4 would ask the AHRQ what's your sense of
5 that? I mean that's -- if you correlate it
6 with prevalence, okay. You know, it's
7 related, you can sort of map it. Maybe it's
8 oversimplifying to say it's related to
9 diabetes but it's pretty closely mapped with
10 diabetes and you can see the slope slip just
11 the same going up. Hospitalizations go up,
12 obesity goes up. But that's dramatic.

13 And it would suggest I think that
14 something is odd about outpatient management
15 when you've got that dramatic an increase in
16 hospitalizations, 110,000 to 150,000 in a 5-
17 year period. Any thoughts about that?

18 MS. OWENS: In terms of why it's
19 happening I don't know and I don't know that
20 AHRQ has a stance in terms of the why.

21 I can tell you that DHHS across the
22 Department we're very concerned about

1 diabetes. It is a high-priority condition.
2 Clearly something is going on and we need to
3 get a handle on it. So there's been
4 multiple initiatives at CMS.

5 AHRQ has done quite a bit of work in
6 terms of on the research aspects. Of course
7 NIH is always doing work in this area. But
8 looking at demonstrations about improving
9 the care for diabetics as well as decreasing
10 hospitalizations in terms of the why I don't
11 know. In terms of yes, it's important, I
12 agree.

13 MR. ROMANO: The only thing I would
14 add is that CDC I think has just reported
15 that there may be a downwards deflection in
16 some of these hospitalization rates just in
17 the last year with similar data from CDC's
18 databases, National Hospital Discharge
19 Survey which is very similar to HCUP. So we
20 may as we look in 2012 and 2013 data might
21 start seeing a change there.

22 DR. SAMPSEL: Jason, do you have

1 comments on evidence?

2 MR. SPANGLER: The section on
3 performance gap. Shall I wait? But we're
4 talking about it now.

5 DR. SAMPSEL: Yes, go ahead, since
6 we're talking about all of these things,
7 that's fine.

8 MR. SPANGLER: Yes, so sorry. Just
9 because we're talking about. I'm just
10 wondering, and thanks for that comment,
11 Patrick, but I'm wondering why -- if you
12 have any reasons why this one, the rates are
13 getting worse whereas if you look at 274
14 which is PQI 3 it's kind of up and down.
15 The one that Marcel and I looked at, 638 or
16 PQI 14, it's actually improving. But this
17 one it's definitely getting worse.

18 And one of the reasons is to see if
19 you have any answers for that. And if you
20 don't, that's fine.

21 But I'm wondering is there something
22 that needs to be done with this measure.

1 Because this measure has been since 2007.
2 And it's not helping at all. It doesn't
3 seem like -- we're measuring this, which is
4 great, but it's not benefitting anything.
5 It keeps getting worse and worse and worse.

6 And is there some modifications we
7 possibly need to make to this measure? Or
8 not? Or is there just factors outside of
9 that? Do we just keep measuring it?

10 I just don't want to keep measuring
11 it and just keep getting worse and worse and
12 worse numbers. Because what's the benefit
13 of even having the measure.

14 DR. SAMPSEL: So Pam and I might --
15 I guess what I wanted to ask is kind of
16 almost similar to what Jason has -- if you
17 can comment with the PQIs and over time they
18 come here for endorsement. But what is your
19 typical almost through evaluation cycle and
20 how are you monitoring the numbers for
21 considerations of measure revision?

22 MS. OWENS: So annually we do look

1 at these measures. And we go through the
2 codes. Are there new codes or whatever.

3 What you're really talking about is
4 not so much the measure itself as much as
5 the use of the measure and is it being used
6 in such a way that there's uptake, that
7 there's an effect right.

8 So -- there's a component in the
9 sense if people don't use it because they
10 don't think it's an effective measure,
11 absolutely. But you know, we have various
12 implementation strategies in place to try to
13 see how people are using the measure and
14 what the uptake is and what the net result
15 is. I don't know where I was going with
16 this conversation.

17 (Laughter)

18 MS. OWENS: All that to be said, I
19 mean, these are based on ICD-9 codes, right?
20 And so if, you know, you parse it out maybe
21 one of the things we certainly can look at
22 analytically, is it one set -- there's

1 basically three groups of codes there. Is
2 it one set of codes that's on the rise
3 versus others. We'd have to look at
4 clinical practice. What the coding --
5 what's going on in terms of with the coding.

6 The measure itself is just capturing
7 short-term complications of diabetes. This
8 is what we have to work with from an ICD-9
9 code book. So, at some level you're
10 somewhat limited.

11 I don't know, Patrick, if you want
12 to say more on this issue. I'm not sure I'm
13 quite answering your question.

14 MR. ROMANO: Well, I think it's a
15 good question. And all we can really do is
16 to speculate. I think that perhaps there
17 are some things that AHRQ and others could
18 do to empirically explore this more. But I
19 might have some concern that this may
20 reflect some up-coding. Because as I
21 mentioned this PQI captures the most severe
22 complications of diabetes which will affect

1 in some cases the MS-DRG assignment.

2 So, it may be that -- and this is
3 part of why we really encourage people to
4 look at the set of PQIs as a set. Because
5 the extent that one is -- for example, this
6 one increasing whereas uncontrolled diabetes
7 is decreasing.

8 That may to some extent reflect a
9 push towards more specific coding of
10 diabetic complications, in other words,
11 avoiding the use of the non-specific 0.9
12 codes in favor of more specific codes that
13 often drive a higher cc level and thus a
14 higher payment.

15 So, I would be cautious about over-
16 interpreting. We could potentially do some
17 empirical analyses to explore whether if
18 this is true, if we're seeing up-coding over
19 time then we might expect the other markers
20 of the marginal severity of these
21 complications to be decreasing over time.

22 In other words, patients should be

1 staying less in the hospital. There should
2 be lower hospital charges over time. But I
3 would have some concern that what you're
4 seeing as you're comparing these different
5 indicators may reflect changes in how
6 they're coding.

7 Of course, the hospital can't get
8 away from coding some type of diabetes
9 complication when they admit something for a
10 diabetes-related problem. But they may pick
11 and choose which particular codes they put
12 first.

13 Not sure if that helps but it is an
14 informed speculation.

15 MR. SPANGLER: That's helpful, thank
16 you.

17 DR. SAMPSEL: Jane and then Eric.

18 MS. CHIANG: So I think part of it
19 is actually a true epidemiologic phenomenon.
20 Where we are seeing increased incidence of -
21 - well, both incidence and prevalence of
22 both types of diabetes. And we are seeing -

1 - with the greater numbers we are seeing
2 greater admissions.

3 The other factor is a lot of primary
4 care physicians don't know how to recognize
5 the issue. And this has been part of the
6 problem as well. Just from, you know, from
7 my perspective.

8 So I don't know if you can just say
9 it's necessarily the tool, but I also think
10 that this reflects what we've seen in
11 practice as well.

12 The other thing I was going to say
13 is just like with all the others the
14 economic analysis, if you're going to use
15 that as an argument there is a paper that we
16 published last year which reflects the 2012
17 economic cost analysis of diabetes.

18 And that reflects a \$245 billion net
19 cost. And then the hospitalization cost is
20 \$176 billion. So you may want to use those
21 numbers.

22 DR. SAMPSEL: Eric, did you have

1 something?

2 MR. FRANCE: Probably just a
3 question about further development of
4 metrics knowing that the prevalence is going
5 up with diabetes across the country and
6 that's embedded in this per 100,000
7 population measure, whether you have other
8 metrics, where you're looking with the
9 denominator being people with diabetes.

10 So that one can look at among people
11 with diabetes is the health systems
12 infrastructure doing a good job of managing
13 them.

14 MS. OWENS: So, excellent question.
15 And as part of the QI program one of the
16 things that we have looked at is can we get
17 county-specific rates of diabetes. So, you
18 know, what's the prevalence of diabetes.

19 And compare that to using a variety
20 of things. And we actually are using CDC
21 data to try to look at that a little bit
22 more in-depth.

1 The other thing -- so to answer that
2 specific question, ongoing. Okay? No
3 definitive answer yet.

4 The other thing is that these PQIs
5 is they are being adopted by various
6 programs whether they be CMS programs or
7 state programs. Some of them are trying to
8 see whether or not they use this numerator
9 in one of these four, but change the
10 denominator such that the denominator
11 reflects the beneficiary population with
12 diabetes. And then they do a lot of
13 reliability and validity testing to see if
14 in fact that indicator is still solid. So,
15 it's an adaptation of the PQI. That's not
16 what's before you for endorsement, but yes,
17 that's being done in terms of being looked
18 at and the testing is underway. Does that -
19 -

20 MR. FRANCE: I think that sounds
21 great. You're always sort of stuck. It
22 actually sort of raises more questions when

1 you see the results. Is this because of the
2 prevalence is increasing and that's why it's
3 flat, or is it because our infrastructure
4 isn't very strong. And so you sort of go
5 into those next level of questions to try
6 and get an answer to that. So it's the
7 limitation of the value of the current
8 metric when it's looked at alone.

9 DR. SAMPSEL: Jane, did you have a
10 final comment before we go to vote? Okay.

11 So, Kaitlynn, I think we're ready to
12 vote. We have, Arjun, you're recusing
13 yourself, correct? And then Mike, you're
14 recusing yourself as well due to involvement
15 on advisory panels or technical expert
16 panels. So, and then Tom has rejoined us so
17 I think we're looking for 19.

18 MS. ROBINSON-ECTOR: This is for
19 evidence and the voting is now open. Two
20 votes are out. I think we've missed one
21 person so we'll have to go back. Voting is
22 open. It looks like one vote is still out.

1 DR. SAMPSEL: So that's pretty
2 clearly yes. And so we'll move on. But
3 basically when you click you should also see
4 a little green light go on, so if folks want
5 to make sure that's happening.

6 MS. MUNTHALI: Maybe you can do a
7 test so that we can make sure everyone's
8 device is working.

9 DR. SAMPSEL: Okay. So this next
10 one will be a test.

11 We'll try again on a test. And
12 everybody, even if you're recusing yourself
13 should be -- you can't recuse yourself from
14 a test. Let's go with that.

15 MS. ROBINSON-ECTOR: Okay, so all of
16 them are working. There's 21.

17 DR. SAMPSEL: All right. So let's
18 just continue to go through. They all
19 worked that time but we do know that first
20 one, unless somebody knows they said no and
21 doesn't come to 1, whatever.

22 But let's go ahead and continue to

1 move through 1. And during our discussion
2 we do go all the way through performance gap
3 and priority. So Kaitlynn, if you could
4 just take us through the two remaining
5 votes.

6 MS. ROBINSON-ECTOR: For performance
7 gap the voting is open. All the votes are
8 in and voting is now closed.

9 DR. SAMPSEL: Jason, you have a
10 question?

11 MR. SPANGLER: Yes, I had a question
12 about this in the other measures around
13 looking at performance gap.

14 We have these observed rates but
15 there's no baseline. Like I don't -- to me
16 that seems bad but is there a good rate?
17 You know what I'm saying? I mean, the rates
18 are variable. Some are rising, some are
19 not.

20 But, I mean, if all of them were,
21 you know, 11, 12, 13, 14, 15 they'd all be
22 worsening. But that would obviously be a

1 lot better.

2 So is there any -- I guess maybe the
3 people who are -- maybe Jane, the
4 endocrinologist.

5 But I mean, not that there's an
6 acceptable rate but as something good versus
7 really bad. I don't know if you guys from
8 AHRQ know. I mean, I don't know what you
9 would say to that.

10 MS. OWENS: It's a good question. I
11 would actually defer to her.

12 MR. SPANGLER: Like an observed
13 admission rate. You know, for these
14 patients. I mean we have rates that are
15 around 50-60 per -- for what they have. So,
16 per 100,000. So, I'm wondering. You know,
17 I'm sure there's some rate that's
18 acceptable, right?

19 MS. CHIANG: I mean ideally it would
20 be zero, right? Where you would educate the
21 -- I think this is multifactorial where if
22 you do have patients who recognize what it

1 is and the providers who recognize it it
2 would be zero. But since that's not the
3 case as low as possible.

4 And I think they're both bad but I
5 think for DKA it's probably a little bit --
6 it's okay to have it a little bit higher
7 than HHS because that's very bad to use your
8 terms.

9 MR. SPANGLER: Got it, thanks. I
10 like those terms, thanks.

11 DR. SAMPSEL: I think, Jason, that's
12 still your card up. It's hard for me to see
13 that far. Go ahead and continue, Kaitlynn.

14 MS. ROBINSON-ECTOR: Seventeen voted
15 for high, two voted for moderate, zero voted
16 for low and zero voted for insufficient.

17 For high priority voting is open.
18 And we're waiting on one vote. All the
19 votes are in and voting is now closed.

20 For high priority 19 voted high,
21 zero voted moderate, zero voted low and zero
22 voted insufficient.

1 DR. SAMPSEL: Okay, John, back to
2 you for reliability and validity.

3 MR. AUERBACH: The reliability is
4 established. And the numerator and
5 denominator are clear. I do have a picky
6 question about the not counting pregnant
7 women in the denominator which I mentioned
8 on the call. It's a minor issue but I do
9 think that data exists and you can actually
10 decrease pregnant women from the
11 denominator. The state data are available
12 for that. But that's a minor point.

13 And the measure has been well tested
14 for reliability.

15 DR. SAMPSEL: Jason?

16 MR. SPANGLER: I had another
17 question for the AHRQ staff. There was no
18 mention through this and several others
19 around ICD-10. And I'm assuming that's
20 something you guys are already planning for
21 when those changes come.

22 MS. OWENS: Right. I'm not sure

1 what was submitted in the Excel
2 spreadsheets.

3 All of these codes have been mapped
4 to ICD-10. We did post it for public
5 comment in December and that public comment
6 period ended on December 25. Good timing on
7 the government's part.

8 But all that to be said we did not
9 receive any comments that suggested we
10 needed to change those mappings. Actually,
11 Patrick and his colleague Ginger Cox are
12 actually at the forefront of doing that
13 mapping.

14 We will have a beta version -- our
15 plan is to have a beta version of all of
16 these indicators mapped to ICD-10 in a SAS
17 program by October 1, 2014. Of course we
18 have been delayed on implementation.

19 MS. MUNTALI: I think there was
20 some confusion on the workgroup. What we
21 received in the Excel spreadsheet was
22 corrupt. And I'm not sure if we got the

1 correct worksheet. But, that's -- we'll
2 include that and share it with the committee
3 once we receive that.

4 DR. SAMPSEL: Other discussion
5 points on scientific acceptability?

6 MR. AUERBACH: I will say --

7 MR. ROMANO: I will say -- this is
8 Patrick. Oh, sorry.

9 MR. AUERBACH: I would defer to him.

10 MS. OWENS: Go ahead, Patrick.

11 MR. ROMANO: I was just going to say
12 that there are some changes as some of you
13 may know in the ICD-10 CM codes. It may
14 lead to some upward or downward movement for
15 some of these individual PQIs.

16 We wouldn't expect the group as a
17 whole to move up or down specifically
18 because of the ICD-10 implementation. But
19 ICD-10 as you may know offers more specific
20 codes for some diabetic complications.

21 It also offers a greater
22 categorization of what's referred to as

1 secondary diabetes, different types of
2 secondary diabetes. So this may have some
3 impact of how cases sort across these four
4 PQIs. That's all I'll say.

5 But anyway, the specifications are
6 available for comment and there will be
7 further testing that will happen over the
8 next year and a half.

9 MS. OWENS: And just to clarify that
10 testing will take dual coded data from the
11 medical records where the medical records
12 have been coded in both ICD-9 and ICD-10.
13 We will be able to determine if you're using
14 the I-9 algorithm was this an identified
15 case.

16 Then the same case, the same record
17 has been also I-9 coded. We'll run it
18 through the I-10 specifications and see if
19 the same case was identified.

20 MR. AUERBACH: So I would say in
21 terms of the issue of validity the
22 specifications align with the evidence of

1 quality as indicated by the testing that has
2 been done.

3 However, I think that as we're
4 talking, as we're discussing it the quality
5 of care is insufficient to explain the
6 dramatic increase in hospitalizations. And
7 that there are complicating factors
8 associated with that which I think are
9 socioeconomic in nature.

10 You know, we see a dramatic
11 difference between diabetes level in Black
12 and Latino communities, for instance, than
13 White communities and in poor communities.

14 So I just think in terms of the
15 validity there's room for more testing and
16 looking at factors other than quality of
17 care as correlated with this.

18 I hope, I don't know if AHRQ is
19 planning on doing that but I think if there
20 are ways of looking at that it would be
21 useful for further considerations.

22 DR. SAMPSEL: Okay, Kaitlynn.

1 MS. ROBINSON-ECTOR: This is for
2 reliability and voting is open. We're just
3 waiting on one more vote. All of the votes
4 are in and voting is now closed.

5 For reliability 14 voted high, 5
6 voted moderate, zero voted low and zero
7 voted insufficient.

8 This is for validity and voting is
9 open. All votes are in and voting is now
10 closed. For validity 11 voted high, 6 voted
11 moderate, 1 voted low and 1 voted
12 insufficient.

13 DR. SAMPSEL: John.

14 MR. AUERBACH: Here as we talk about
15 the data sources, discharge, diagnostic
16 claims, easily and readily available
17 electronically as well as on paper.

18 DR. SAMPSEL: Any other discussion
19 points? Okay.

20 MS. ROBINSON-ECTOR: This is for
21 feasibility and voting is now open. All
22 votes are in and voting is now closed.

1 For feasibility 18 voted high, 1
2 voted moderate, zero voted low and zero
3 voted insufficient.

4 MR. AUERBACH: So with usability
5 this is currently widely in use as a measure
6 in at least 12 states and by CMS, and has
7 been in use for some time.

8 With regard to the improvement over
9 time and the usefulness of data I think
10 we've already discussed that, that
11 disturbing that -- that while we're looking
12 at this it doesn't appear to be useful in
13 terms of improving care but nonetheless it
14 is widely utilized as a measure of -- as a
15 quality measure.

16 DR. SAMPSEL: Other discussion
17 points on usability or questions. Jane?

18 MS. CHIANG: So we know that this is
19 usable. It's been used in the past. But is
20 it the best? And so from my information
21 would this be considered -- so for example,
22 if we continue using it as is it sounds

1 fine. I would rate it a high.

2 But if we were to incorporate some
3 of the suggestions that would be better. So
4 how would that influence my voting? So
5 would that be a moderate or low?

6 MS. OWENS: No, you need to consider
7 --

8 MS. CHIANG: As is?

9 MS. OWENS: -- as is, as when
10 presented.

11 DR. SAMPSEL: Okay, Kaitlynn.

12 MS. ROBINSON-ECTOR: This is --

13 MR. ROMANO: One question, a brief
14 point. The question was raised earlier
15 about what's the right rate or how do we
16 point people towards what they should be
17 able to achieve.

18 There is a concept called achievable
19 benchmarks that we sometimes recommend which
20 basically points the 20th or 25th percentile
21 as the empirical distribution as what should
22 be an achievable benchmark for most areas.

1 So, in this case, again, recognizing
2 the ideal rate would be zero but very few if
3 any communities are able to achieve a zero
4 rate.

5 However, 25 percent are able to
6 achieve a rate of 40 which is less than half
7 of the 75th percentile and less than one-
8 third of the 95th percentile. So, that's
9 the general approach that we use sometimes
10 to steer people towards what should be
11 achievable for most areas.

12 MS. ROBINSON-ECTOR: This is for
13 usability and voting is now open. All the
14 votes are in and voting is now closed.

15 For usability 13 voted high, 4 voted
16 moderate, 2 voted low and zero voted
17 insufficient information.

18 DR. SAMPSEL: So our next vote will
19 be for the overall suitability for
20 endorsement. Any additional comments,
21 reflections, discussion points before we
22 vote yes or no on this one? Okay. Oh,

1 Robert.

2 MR. VALDEZ: I just wanted to say
3 that it's important as we began our
4 discussion to recognize that this is one of
5 a set of measures. This one taken alone
6 probably doesn't tell us a lot, but taken in
7 combination with others is probably the one
8 that gives us some answers to some of the
9 questions that have been bandied about.

10 MS. ROBINSON-ECTOR: This is for
11 overall suitability for endorsement. Voting
12 is now open. We're waiting on one more
13 vote. All the votes are in and voting is
14 now closed.

15 For overall suitability for
16 endorsement for measure 0272 Diabetes Short-
17 Term Complications Admission Rate PQI 01 19
18 voted yes and zero voted no. The measure
19 passes.

20 DR. SAMPSEL: Okay, great. So we're
21 now going to move onto 0274 and in our
22 workgroup summaries if folks are looking at

1 that that's page 7. And discussants, I
2 think Emilio, are you ready to lead this?
3 He is.

4 And I think as with the past measure
5 Arjun and Mike, you are both continuing to
6 recuse yourselves, correct? Yes?

7 MR. STOTO: I'm not recusing myself
8 from this one.

9 DR. SAMPSEL: Oh, you're not. Okay.
10 We'll put you back on the list. So go
11 ahead, Emilio.

12 MR. CARILLO: Yes. As has been said
13 this is part of a suite of measures which
14 taken as a whole has increased value.

15 It's an outcome measure. The 0274
16 which is the diabetes long-term
17 complications admission rate PQI 3.

18 It's sole source. It's
19 administrative claims which we've discussed
20 has issues here and there but it's something
21 that we see throughout all of our measures.

22 It is population-based and there is

1 a very well established path between
2 diabetes and long-term complications
3 associated with microvascular damage.

4 We have the United Kingdom
5 Prospective Diabetes Study, famous UK PDS
6 study that has shown great relationship
7 between the two.

8 And in terms of the evidence, I mean
9 there's a number of evidence-based
10 guidelines that are based on this pathway.
11 So clearly there's good evidentiary value to
12 this.

13 Not that it makes a significant
14 difference given how we are choosing
15 principal diagnosis across the board, there
16 could be a significant underreporting of
17 diabetes long-term complications.

18 The National Hospital Discharge
19 Survey, the CDC in 09 showed that there
20 were 688,000 discharges with a principal
21 diagnosis of diabetes mellitus as opposed to
22 5 and a half million if you look at the top

1 seven discharge diagnoses. But
2 understanding that we do have the standard
3 of the principal diagnosis.

4 The issues regarding social impact,
5 the MSA, level of analysis, zip code versus
6 greater county, those issues apply just like
7 they did in all the previous discussions.

8 In terms of the specifications I
9 would again raise an issue that Ron and
10 others have raised which is stratification
11 being of value.

12 In determining predictive value the
13 measure developers just looked at age and
14 gender as covariates and perhaps racial and
15 ethnic covariates and other SES covariates
16 would give further value.

17 So, again, let me stop there and get
18 any other comments in terms of evidence.

19 DR. SAMPSEL: Any discussion items
20 on evidence? Jane?

21 MS. CHIANG: This is a question for
22 AHRQ. So, if someone is discharged from the

1 hospital with let's say a heart attack but
2 they don't co-code for diabetes, is that
3 captured?

4 MS. OWENS: So, this is a principal
5 diagnosis of diabetes. And so, that
6 particular instance where you're telling me
7 that the principal diagnosis after all is
8 said and done, that the reason for the
9 hospitalization was the heart attack, that
10 would not be captured here. Right?

11 MS. CHIANG: Because that happens a
12 lot, where a lot of times people are -- the
13 primary condition is not captured. And I
14 think for the sake of this it kind of
15 influences the way I see the evidence.

16 MS. OWENS: Patrick, can you inform
17 the group? Because I know you were involved
18 in the development. Was this taken into
19 consideration? And what the thoughts were?

20 MR. ROMANO: No, that's exactly
21 right. I mean, these are not measures of
22 the total population burden resulting from

1 diabetes. So, clearly if you were to tally
2 all diabetes-related hospitalizations in the
3 United States the total would be much
4 greater. So these are hospitalizations that
5 are specifically linked to identified
6 diabetes complications, neurologic
7 complications, diabetic gastroparesis, so
8 forth.

9 And therefore it is an undercount
10 given that the cardiovascular complications
11 of diabetes are of course what take the
12 largest toll in terms of deaths.

13 If we were to include those the
14 numbers would be even greater. But of
15 course we have to then figure out some way
16 to apportion which of those, for example,
17 diabetes-related MIs are actually linked to
18 diabetes.

19 In the case of the long-term
20 complications that are included here we rely
21 on physician labeling and the coding to say
22 that diabetic gastroparesis, for example, is

1 ipso facto a result of poorly controlled
2 diabetes over time. Similarly for diabetic
3 neuropathy.

4 So, it's just a matter of sort of
5 separating those complications that are more
6 intrinsically linked to the diabetes versus
7 those that are multifactorial where diabetes
8 is clearly a contributing factor but it's a
9 little bit more difficult to assign the
10 complication definitely being due to
11 diabetes. Does that make sense?

12 MR. CARILLO: Perhaps before voting
13 I could just make a comment on performance
14 and high priority. Or we'll discuss that
15 later?

16 DR. SAMPSEL: Sure, that's fine.
17 Sure, go ahead.

18 MR. CARILLO: Just, again, nothing
19 earth-shaking. In terms of performance gap
20 there is a very solid robust gap. The
21 developer looked at HCUP data from 07 to
22 11. Very, very robust distribution of

1 scores, 5th to 95th percentile.

2 And also ethnic and racial minority
3 disparities exist and well documented. They
4 cite 51 studies and there's probably more
5 than that.

6 And I -- you know, our group in this
7 discussion felt that this is a high
8 priority, well demonstrated,
9 pathophysiologic chain, and affecting large
10 numbers. A significant cause of morbidity
11 and mortality and major resource
12 consumption.

13 DR. SAMPSEL: Great. So, hearing
14 anything else? Tom.

15 DR. MCINERNEY: Now, I'm a little
16 confused. Because I worry about this
17 coding. As someone mentioned it has to be
18 coded as a complication of diabetes? What
19 happens if the code, the first code is renal
20 failure? And the reason for the renal
21 failure is because the patient has diabetes.
22 Now, how is that coded?

1 And I think in some instances -- I
2 don't understand the coding. Do you
3 understand how that works?

4 MS. CHIANG: It really is physician-
5 dependent. But one thing that frequently
6 happens is diabetes is not captured as the
7 primary etiology behind the cause.

8 So, we know that a lot of deaths,
9 for example, are due to myocardial
10 infarction related to macrovascular disease.
11 But that is not captured. It just says
12 myocardial infarction.

13 So it's a problem because you can't
14 capture the enormity of this disorder
15 because the main reason for the death is not
16 identified.

17 DR. MCINERNEY: And then to further
18 complicate matters what happens if the
19 diabetic patient is also a smoker? And then
20 how does that color it?

21 MR. SALIVE: Yes, so I think this is
22 why that's not a big deal. You know, the

1 things you're talking about have
2 multifactorial causes. And we can't sort it
3 out in claims data. It's really a blunt
4 instrument. We're looking for preventable
5 complications here which I think if they say
6 that's why they were admitted, it's the
7 principal diagnosis, okay, enough.

8 Because there's one million heart
9 attacks a year and sure, some fraction are
10 due to diabetes, but we don't know what
11 fraction and we don't know which admissions.
12 And that's not the focus of this measure.
13 So, you know, very interesting discussion.

14 MS. CHIANG: But I actually disagree
15 because I think that if we're the health and
16 well being group that it is a preventable
17 measure.

18 So, for example, the UK PDS, the
19 Diabetes Control and Complications Trial all
20 showed that if you can reduce your A1c --
21 they did show that in the DCCT trial and the
22 UK PDS. It did show that if you decrease

1 your Alc to have more intensive management
2 you can have improved retinopathy decreases,
3 all of those factors decrease.

4 So I think it is important. Whether
5 we can do something about that, I think
6 that's a different story. But if you can
7 control the disease you can control long-
8 term outcomes.

9 But that's a separate topic I think
10 from what we're trying to do here which is
11 really to say is this measure effective.

12 MR. STOTO: I would build on that
13 last thing. The question is is this measure
14 good. We're not trying to sort out whether
15 every one of these cases is or is not due to
16 diabetes. The question is do they assist us
17 in making comparisons over time and between
18 locations that are helpful.

19 And to the extent that the fractions
20 of cases missed or reported incorrectly are
21 relatively constant I think the measures
22 work.

1 MR. CARILLO: Just to clarify
2 something that maybe is clear already, that
3 we're talking microvascular damage. So,
4 heart attacks are not part of that. That's
5 macrovascular.

6 MR. ROMANO: Just one clarification
7 of coding rules.

8 So, coding rules do specify that if
9 a patient is admitted with acute or chronic
10 kidney failure and they have a diagnosis of
11 diabetes then the default position for the
12 coder is that it gets coded as a diagnostic
13 complication, as diagnostic nephropathy.

14 That is not always true but for all
15 diabetic complications, it's not true for
16 cardiac complications, but it is true
17 specifically for renal complications. The
18 default position for coders is to assume
19 that nephropathy in a diabetic is diabetic
20 nephropathy and therefore it gets captured
21 here.

22 Of course there may be some cases

1 where the physician fails to diagnose
2 diabetes at all on a record of a
3 hospitalized patient. That hopefully is not
4 too common but it could happen.

5 DR. SAMPSEL: Thank you, Patrick.
6 Go ahead, Kaitlynn.

7 MS. ROBINSON-ECTOR: This is for
8 evidence. And voting is open. All the
9 votes are in and voting is now closed.

10 For evidence, 19 voted yes and 1
11 voted no.

12 This is for performance gap and
13 voting is now open. We're waiting on one
14 more vote. For performance gap 15 voted
15 high, 4 voted moderate, zero voted low and
16 zero voted insufficient.

17 This is for high priority and voting
18 is now open. We're waiting on one vote.
19 All the votes are in and voting is now
20 closed. For high priority 18 voted high, 1
21 voted moderate, zero voted low and zero
22 voted insufficient.

1 MR. CARILLO: Reliability. The
2 metric of reliability is signal-to-noise
3 ratio. And developers and AHRQ have done
4 two sets of measurements on this. And both
5 come in very positive. So there is good
6 evidence to support the reliability of this.

7 DR. SAMPSEL: Any other comments on
8 reliability? All right, let's go to vote.

9 MS. ROBINSON-ECTOR: This is for
10 reliability and voting is now open. All the
11 votes are in and voting is now closed. For
12 reliability 17 voted high, 2 voted moderate,
13 zero voted low and zero voted insufficient.

14 MR. CARILLO: The workgroup had
15 concerns about the validity of this measure.
16 The very fact that it takes decades to
17 develop the microvascular damage, it's
18 significant.

19 This is very different than the
20 measure of asthma which is something that
21 happens acutely or subacutely. This is
22 different than what happens in short-term

1 measures of diabetes complications.

2 We're talking about complications
3 that take 15-20 years, maybe more to
4 develop.

5 So what are we measuring? When we
6 measure -- when we get a measure of these
7 long-term complications what if we have a
8 community, say, in New Mexico where a new
9 Kaiser comes in, rolls in and over 10 years
10 develops a whole set of primary care
11 opportunities. And you may be measuring
12 what was there before Kaiser came in, 10
13 years before, 15 years before.

14 And conversely, if you have an area
15 that loses their main industry, sort of a
16 Detroit effect and over 10 years the
17 industry is gone, the primary care is gone,
18 and the measures that you get may reflect
19 life before the industry left.

20 So I think that there has to be real
21 care in how we use this measure. Again, as
22 a suite of measures that possible

1 confounding is diminished. But nevertheless
2 I think that there's something oxymoronic
3 about this.

4 DR. SAMPSEL: Other comments about
5 validity? Okay, Kaitlynn.

6 MS. ROBINSON-ECTOR: This is for
7 validity and voting is open. All the votes
8 are in and voting is now closed.

9 For validity, 4 voted high, 10 voted
10 moderate, 4 voted low and 1 voted
11 insufficient.

12 MR. CARILLO: The feasibility was
13 discussed by the group and all felt that
14 there's feasibility at all levels, public
15 health departments, researchers, ACOs, HMOs.
16 And it's a positive statement.

17 DR. SAMPSEL: Any discussion around
18 feasibility?

19 MS. ROBINSON-ECTOR: This is for
20 feasibility and voting is open. We're
21 waiting on one more vote. All the votes are
22 in and voting is now closed.

1 For feasibility 19 voted high, zero
2 voted moderate, zero voted low and zero
3 voted insufficient.

4 MR. CARILLO: And finally, in terms
5 of usability and use this has been around
6 since the eighties. And my friend here from
7 L.A. -- you didn't use this measure? Well,
8 I take that back. This has been around for
9 a long time.

10 (Laughter)

11 MR. CARILLO: I was trying to give
12 him credit for something. And it's been
13 very useful.

14 DR. SAMPSEL: Any other discussion
15 about usability? Kaitlynn.

16 MS. ROBINSON-ECTOR: Voting is open.
17 There's one more vote left. One more vote
18 still out.

19 So for high, 10 voted for high, 7
20 voted for moderate and 2 voted for low.

21 DR. SAMPSEL: Okay, next vote is
22 overall suitability for endorsement. Any

1 additional discussion items? Anything else
2 folks would want to comment to AHRQ? Okay,
3 let's vote.

4 MS. ROBINSON-ECTOR: Voting is open.
5 All the votes are in and voting is now
6 closed. For overall suitability for
7 endorsement for measure 0274 Diabetes Long-
8 term Complications Admissions Rate PQI 3, 18
9 voted yes and 1 voted no. So the measure
10 passes.

11 DR. SAMPSEL: Great. Two more PQIs.
12 We're going to change things up a little bit
13 here and go to amputation. And I'll ask as
14 before if Pam, if you will make some
15 introductory comments. And then I believe
16 our lead discussant is Patricia for this
17 one. Great. So, Pam?

18 MS. OWENS: I don't have any
19 additional comments other than what I said
20 at the beginning which is the potential to
21 bring this in with the other measure.

22 MR. FRANCE: Is there time for a

1 break, Sarah? I think 10:45 had us at a
2 break.

3 DR. SAMPSEL: Sure, we'll go ahead
4 and take a break. We were going to try to
5 get through but why don't we go ahead and
6 give folks some -- 10 minutes to stretch
7 your legs.

8 (Whereupon, the foregoing matter
9 went off the record at 11:09 a.m. and went
10 back on the record at 11:15 a.m.)

11 DR. SAMPSEL: Okay, we're going to
12 make just a real minor change to the
13 schedule. We're going to go ahead and
14 actually move 0638 the uncontrolled diabetes
15 admission rate up just because it is so
16 similar to the other measures.

17 And perhaps we can make some
18 efficiencies out of discussions we've
19 already had. But we do still need to go
20 through the process and have those
21 discussion items where warranted and where
22 committee members want to bring up

1 considerations.

2 We'll then do the amputation and
3 diabetes measure, and then go ahead to the
4 NCQA breast cancer screening measure.

5 We're just trying to adapt to being
6 a little bit behind schedule and knowing
7 that some of the measure developers will
8 have to leave between 12 and 1.

9 So with that 0638 -- I promise,
10 Patricia, we'll come back to you -- 0638 was
11 Marcel and Jason. And I don't know which of
12 you was going to lead.

13 MR. SALIVE: I'll take it since
14 Jason left the room.

15 (Laughter)

16 MR. SALIVE: He must have heard wind
17 of this plan.

18 So this measure is for principal
19 diagnosis of diabetes without -- as I said I
20 think about an hour ago without mention of
21 the other complications that we've just gone
22 through. So, it is a complement to those

1 last two measures we just looked at.

2 And it's described on the screen. I
3 think it's still an ambulatory-sensitive
4 condition, avoidable hospitalization.

5 The rationale being that the
6 management of diabetes is done as an
7 outpatient and does not need to be done in
8 the hospital. So I think that's the -- it's
9 an outcome measure with the rationale.

10 The measure is pretty stable I think
11 over time, but it does show variation with
12 respect to certainly age. It's very
13 increasing with age considerably and highest
14 in the 75-plus age group.

15 There is a performance distribution
16 score, distribution I guess as mentioned by
17 the developers. So the 25th percentile is
18 8.6 and then the highest, it gets up to like
19 40. It's been stable so there is a gap.

20 I think, you know, we don't have to
21 discuss the importance of diabetes. It's
22 hugely important. So I think I covered the

1 first three right there albeit efficiently
2 and quickly.

3 DR. SAMPSEL: Appreciate it. We
4 don't want to stunt conversation at all. So
5 at that are there additional comments,
6 questions, considerations for this measure?
7 And Pam, did you have anything you wanted to
8 add? Jane?

9 MS. CHIANG: This is more
10 informational but where is the information
11 captured for those less than 18? Is that
12 something that's captured, or is that part
13 of this discussion?

14 MS. OWENS: We have a different set
15 of measures called the pediatric quality
16 indicators and that's -- the two that you
17 looked at this morning were pediatric
18 quality measures.

19 In terms of in the pediatric quality
20 measure set, let's see, we do have a
21 diabetes short-term complications rate.
22 That has not been brought to NQF for

1 endorsement.

2 DR. SAMPSEL: Other comments on
3 evidence, opportunities for improvement,
4 gaps, et cetera? And who is recusing from
5 this one? Arjun? No? Mike, no? Okay. Go
6 ahead, Kaitlynn.

7 But Kaitlynn, we're missing Jason
8 and Tom. Yes.

9 MS. ROBINSON-ECTOR: This is for
10 evidence. And the voting is open. There's
11 one more vote out. So for evidence 19 voted
12 yes and zero voted no.

13 This is for performance gap and
14 voting is now open. One vote is out. All
15 votes are in and voting is now closed. For
16 performance gap 18 voted high, 2 voted
17 moderate, zero voted low and zero voted
18 insufficient.

19 This is for high priority and voting
20 is open. One vote is out. All votes are in
21 and voting is now closed. For high priority
22 18 voted high, 1 voted moderate, 1 voted low

1 and 1 voted insufficient.

2 DR. SAMPSEL: Okay, Jason or Marcel,
3 scientific acceptability, validity,
4 reliability.

5 MR. SALIVE: Okay. So this one,
6 again, it's a measure that's been endorsed
7 in the past. It's coming for resubmission.

8 They used for reliability the
9 signal-to-noise ratio and presented some
10 data on that which was -- the developers
11 have judged that as moderately reliable.

12 They did the construct validity
13 testing looking at structural measures to
14 predict and substantial evidence was
15 presented on that construct validity.

16 I think on the call we did have some
17 discussion about some possibilities of
18 misclassification just that might affect
19 validity as a family of measures. I think
20 that accounts for some of the possible
21 misclassification.

22 DR. SAMPSEL: Mike?

1 MR. STOTO: I just want to say that
2 we have to really think about this as part
3 of a family of measures. By itself it's
4 probably -- it's kind of a leftover
5 category. It doesn't have that much
6 meaning. If that's so indicated.

7 DR. SAMPSEL: Eric?

8 MR. FRANCE: In that same line I was
9 just thinking that with these very small
10 rates of 18, 17 per 100,000 events in the
11 context of these other metrics that are
12 being followed by counties what is added by
13 having this third metric, except for the
14 fact that it accounts for some things that
15 might not be otherwise be classified.

16 So it might be a conversation for
17 later when we're talking about harmonization
18 across measures. Is there a utility in
19 tracking this over time and is it reliable
20 in small communities given the low rates, or
21 could it be potentially blended into the
22 short-term outcomes, for example, as a

1 future metric.

2 DR. SAMPSEL: Arjun?

3 MR. VENKATESH: I think you can
4 almost answer that question a little bit. I
5 think the benefit of having this measure is
6 that for measures like this where you have
7 this risk of misclassification across
8 categories there's always some measure
9 reliability that you'll lose with coding
10 drift over time, or potential gaming.

11 And so by basically giving yourself
12 the last piece of the pie I think it helps
13 the other measures that you know over time
14 whether or not to look for things like
15 coding drift or gaming.

16 MR. SALIVE: And I think the
17 developers did present data suggesting it's
18 reliable to communities of size greater than
19 15,000 population which is not too bad.

20 DR. SAMPSEL: Eric, did you have
21 another comment?

22 MR. FRANCE: I don't know, I just

1 didn't make the mental connection about how
2 coding drift or gaming is somehow helped by
3 having this third category.

4 MR. VENKATESH: It would be more
5 that if you didn't have this category then
6 over time instead of coding things as short-
7 term complications then they get coded in
8 this category and completely unmeasured.

9 So while you think you're doing
10 better because your short-term complication
11 rate is declining in the absence of this
12 measure you wouldn't see this going up. And
13 so having this measure lets us know if
14 people are -- instead of being in one bucket
15 are getting coded in a different bucket.

16 MR. ROMANO: I might add one other
17 point.

18 MS. OWENS: Go ahead, Patrick.

19 MR. ROMANO: Yes, it's just to point
20 out that from the standpoint of healthcare
21 interventions there's a second pathway
22 that's relevant to this particular indicator

1 which relates to vascular care.

2 So there's ongoing efforts of course
3 to reduce amputation rate by improving
4 vascular care which would include both
5 potential re-vascularization of patients
6 with peripheral arterial disease as well as
7 better treatment of lower extremity ulcers
8 in patients who have diabetic vascular
9 disease.

10 So, this is an indicator the
11 vascular surgeons and vascular programs are
12 particularly interested in for that reason.

13 MS. OWENS: So, Patrick, that
14 actually applies -- we switched orders on
15 you, sorry. I think you're talking about
16 the lower extremity amputation measure.

17 MR. ROMANO: Oh, I am. I'm sorry.
18 I came into the discussion at the wrong
19 time. Sorry about that.

20 DR. SAMPSEL: We're just trying to
21 keep you on your toes, make sure you're
22 still awake.

1 So with that if there are no other -
2 - oh sorry, Jane.

3 MS. CHIANG: So, I understand why
4 you would have this measure, but one thing
5 that -- because some people just admit
6 because someone is not in control, and
7 that's the way you would manage these
8 patients.

9 I want to reiterate my concern again
10 about capturing hypoglycemia as a specific.
11 I heard that it was part of this but I don't
12 see it as a specific call-out. And I think
13 that that would be very useful.

14 MR. ROMANO: So I'm sorry, just to
15 be clear, are you suggesting that there
16 should be a separate indicator for the
17 hypoglycemic complications versus
18 hyperglycemic?

19 MS. CHIANG: Correct.

20 MR. ROMANO: Okay. Well, that is
21 something that could be evaluated and
22 tested.

1 DR. SAMPSEL: Any other comments?
2 Okay, Kaitlynn, can you lead us through
3 reliability and validity?

4 MS. ROBINSON-ECTOR: Voting is open.
5 All votes are in and voting is now closed.
6 For reliability, 9 voted high, 11 voted
7 moderate, zero voted low and zero voted
8 insufficient.

9 Voting is open. All votes are in
10 and voting is now closed. For validity, 4
11 voted high, 15 voted moderate, 1 voted low
12 and zero voted insufficient.

13 DR. SAMPSEL: Marcel, feasibility?

14 DR. SCHREIBER: Feasibility. It's a
15 claims data measure and uses a population-
16 based denominator from Census data. I have
17 no concerns about that for this measure.

18 It's used by many -- CMS and Monarch
19 and numerous states report it so it has high
20 usability. And we've discussed the other
21 measures.

22 DR. SAMPSEL: Other comments,

1 questions, feasibility? Okay.

2 MS. ROBINSON-ECTOR: For feasibility
3 and voting is open. All votes are in and
4 voting is now closed. For feasibility 19
5 voted high, 1 voted moderate, zero voted low
6 and zero voted insufficient.

7 DR. SAMPSEL: Okay, Marcel, you just
8 commented on usability. Were there any
9 other comments or considerations for
10 usability? Okay.

11 MS. ROBINSON-ECTOR: Voting is open.
12 All votes are in and voting is now closed.
13 For usability 13 voted high, 6 voted
14 moderate, 1 voted low and zero voted
15 insufficient information.

16 DR. SAMPSEL: Okay, any final
17 comments before overall suitability for
18 endorsement? Great.

19 MS. ROBINSON-ECTOR: Voting is now
20 open. All votes are in and voting is now
21 closed. For overall suitability for
22 endorsement for measure 0638 Uncontrolled

1 Diabetes Admission Rate PQI 14, 19 voted yes
2 and 1 voted no. So the measure passes.

3 DR. SAMPSEL: Okay, now we're going
4 to go to 0285 Rate of Lower Extremity
5 Amputation Among Patients with Diabetes. I
6 believe Pam had already made minor comments
7 and Patricia, you're going to kick us off.

8 MS. MCKANE: Okay. This measure is
9 for admissions, any listed diagnosis of
10 diabetes and any listed procedure of lower
11 extremity amputation per 100,000 population
12 ages 18 years and older.

13 It excludes any listed diagnosis of
14 traumatic lower extremity amputation
15 admissions, toe amputation admissions which
16 are likely to be traumatic, obstructed
17 admissions and transfers from other
18 institutions.

19 It's using the same data source as
20 this whole family has been using. As
21 Patrick spoke out on this about the
22 rationale and the evidence this is an

1 outcome measure. The workgroup agreed with
2 the measure that the focus of inadequate
3 diabetes management screening will prevent
4 lower limb amputation linked to diabetes.

5 So we felt that this measure -- we
6 had many of the same concerns that were
7 addressed earlier regarding the data source,
8 regarding the fact that there's other
9 factors that could contribute to this that
10 may be confounding this outcome.

11 It's a bit more distal than perhaps
12 some of the others. And our workgroup
13 summary, it does allow comparison across
14 regions. This is increasing. We do see
15 that measure -- to assess preventive
16 education, outpatient care and management of
17 diabetes and access to care where these
18 resources are lacking since high-quality
19 education and care management and early
20 intervention has been shown to result in
21 lower rates of amputation linked to
22 diabetes.

1 We thought this needs to be, again,
2 within the context or even possibly changed
3 to a composite measure.

4 We also talked about using a
5 geocoded data set to allow a more precise
6 estimate, and particularly to pinpoint high-
7 risk neighborhoods.

8 Again, just there were also
9 disparities by income, region, gender and
10 age that we noted. Prevalence I believe is
11 increasing. Again, this may be a lower
12 prevalence but it is a really extreme
13 outcome. And I can't remember the other
14 things we were supposed to talk about.

15 So I guess I will leave it to my
16 workgroup to fill in any blanks that I may
17 have left out, things that you don't think I
18 covered.

19 DR. SAMPSEL: Jane?

20 MS. CHIANG: So, actually lower limb
21 amputations, the rate has gone down
22 tremendously over the past 10 years. So

1 that's the one area where there's been a
2 significant difference. The data doesn't
3 capture it here, but in general this is one
4 area where I think it's like 45 percent
5 where it's gone down.

6 Prevalence has gone up for diabetes
7 as a whole but because people are aware and
8 there's better vascular maintenance I guess
9 it has gone down substantially.

10 MS. MCKANE: Okay, I was going by
11 what was in the packet.

12 MR. AUERBACH: And what would be the
13 reason that that wouldn't be captured in
14 these rates? Do you have an explanation for
15 that? Because this shows the rates going
16 up.

17 MS. MCKANE: Right.

18 MS. OWENS: Exactly. So, the data
19 that you're looking at, it would be useful
20 for us to look at why there's this
21 discrepancy. Because in fact it looks like
22 it's doing the opposite. I don't know why

1 that is.

2 MR. FRANCE: I would imagine it's
3 the rate per 100,000 population versus a
4 rate per 100,000 diabetic patients. So
5 you're seeing the reduction in diabetics.
6 And then -- which is staying flat because
7 the incidence of diabetes is high.

8 MS. OWENS: Right.

9 DR. SAMPSEL: Arjun?

10 MR. VENKATESH: The other thing is
11 that all these measures are visit rates. So
12 if, for example, somebody had four
13 hospitalizations for each being one to
14 amputation it's counted four times versus
15 previous event may have been multiple toes
16 amputated at once. And so for all the PQI
17 measures these are events, not patients.

18 DR. SAMPSEL: Other comments in the
19 evidence area? John.

20 MR. AUERBACH: So I guess if in fact
21 this isn't the best measure of what's
22 actually happening, I guess I'm just raising

1 a question about that. Is there something
2 we're missing in terms of this that might
3 allow us to better understand what these
4 trends are?

5 MS. OWENS: Patrick, I'm going to
6 defer to you because perhaps -- I'm not
7 actually familiar with what you're saying.
8 I'm not doubting it, but I'm just not
9 familiar with it.

10 Patrick, do you know, have you
11 discussed some of the discrepancy that may
12 be coming out of the endocrine societies
13 versus what HCUP is showing?

14 MR. ROMANO: Yes, I think that the
15 discussion -- I would agree with the
16 discussion thus far.

17 So there are two countervailing
18 trends. One is the increasing prevalence of
19 diabetes and the second is a decreasing
20 amputation rate among patients with
21 diabetes. So those are basically washing
22 out. So we're seeing effectively no change

1 in the rate of this indicator.

2 So it ties into previous discussion
3 of -- as we move towards potentially
4 adjusting all of these diabetes-related PQIs
5 for diabetes prevalence at the community
6 level that would fix the problem.

7 But of course the problem is getting
8 sufficiently reliable and valid estimates of
9 diabetes prevalence at the individual
10 community level. So it works well for big
11 cities. It becomes more problematic for a
12 lot of our larger states that have large
13 rural populations.

14 The other thing I would say is that
15 we have had some discussions and certainly
16 would be interested in the steering
17 committee's input on this.

18 So some have argued in favor of
19 removing toe amputation from the
20 specification here for just the reason that
21 was mentioned, that in some cases the toe
22 amputation is something that has relatively

1 little functional effect but forestalls
2 progression and prevents a more functionally
3 significant proximal amputation.

4 In addition, some patients do come
5 back for multiple amputations of multiple
6 toes and that may be seen as inflating the
7 numerator.

8 So, we've had some discussion about
9 this internally. I'd be interested in the
10 steering committee's input actually about
11 whether toe amputations should be removed
12 from the specification.

13 MS. OWENS: So, Patrick, in our
14 submission we submitted it with toe
15 amputation excluded.

16 MR. ROMANO: Oh you did, okay.

17 MR. FRANCE: It's a bit confusing
18 actually because under the ICD-9 codes
19 listed here it says toe amputation is in the
20 numerator. And then under the excluded case
21 it says with any listed procedure codes for
22 toe amputation.

1 MS. OWENS: Okay, so what that says
2 to me is I need to go back to our
3 documentation as well as our SAS code
4 because clearly there's an inconsistency.
5 Thank you for pointing that out.

6 So, back to Patrick's point then,
7 does the steering committee want to have a
8 conversation about it. And I apologize that
9 it's neither clear to me nor in our
10 documentation.

11 MR. ROMANO: Right. I think the
12 intent was to remove it. But it appears
13 that the language is not consistent. So,
14 the intent was to remove it.

15 DR. SAMPSEL: So, if there is an
16 interest in discussion on changing the
17 specifications of this before consideration
18 then we would want to put this measure on
19 hold and not vote on it right now.

20 So I look to the committee on if you
21 want to consider the toe amputation issue,
22 if those adjustments need to be made. And

1 if they do then we would put this on hold
2 and bring it back versus go through a vote
3 on it.

4 MS. OWENS: So, if it's okay with
5 you and it's possible to put it on hold, up
6 to the committee.

7 But I would like clarification on
8 what we're actually doing. I'm not sure
9 that I can have a discussion when I can't
10 articulate without seeing the SAS code what
11 these numbers are based on. And I think you
12 guys deserve to know that.

13 MS. MUNTALI: I think Sarah was
14 speaking in the interest of time. We're
15 also trying to accommodate NCQA who has a
16 hard stop in about 45 minutes.

17 And so we're saying put it in hold
18 as in moving it a little further in the
19 agenda. And I think there are a lot of
20 issues we need to talk about. And we
21 wouldn't be able to vote it sounds like to
22 accommodate them as well. So I hope that's

1 fair. And I just responded to your email.

2 MR. SALIVE: Do you mean today or
3 some other day? Because I think it affects
4 -- I mean I'm just going to speak in favor
5 of holding it, but I have other issues too.

6 MS. MUNTHALI: Today.

7 MR. SALIVE: That haven't been
8 discussed.

9 MS. MUNTHALI: Today. This is just
10 scheduling. It will be the next measure we
11 talk about after the breast cancer screening
12 measure.

13 DR. SAMPSEL: So, what we're going
14 to do then is go ahead and put this on hold.
15 We will come back to it after the breast
16 cancer screening measure.

17 I know, Pam, you need to leave,
18 correct? But thank you. And Patrick, are
19 you able to stay on?

20 MR. ROMANO: Can you tell me when to
21 come back on?

22 DR. SAMPSEL: Yes, we can send you

1 an email and let you know when to come back
2 on since there are technically two
3 additional PQIs in addition to this one.

4 MR. ROMANO: Okay, thank you.

5 DR. SAMPSEL: Okay. So we'll go
6 ahead and move to breast cancer screening
7 and at least the vote on this and additional
8 discussion on this one on hold.

9 MS. OWENS: And for the committee's
10 purposes AHRQ is still very much hearing
11 what you have to say. Carol Stocks who just
12 joined the AHRQ QI team will be -- is on the
13 phone and will be listening to comments when
14 the PQIs come back up as well as I will get
15 a very detailed transcript.

16 So please continue to provide those
17 comments because I need them to improve the
18 measures as well as integrate them in terms
19 of how we disseminate and what we put in our
20 documentation. Thank you.

21 DR. SAMPSEL: So we're now switching
22 gears to breast cancer screening and are

1 joined at the table with Sepheen Byron from
2 NCQA. And we'll just get those slides up
3 and get started.

4 Okay, so this is measure number
5 2372. We're trying to find the page in the
6 workbook and we'll let you know. But we
7 will have Sepheen do a brief introduction.
8 And then Katie, are you prepared to discuss?
9 Great.

10 We're also joined by Mary Barton.

11 MS. BYRON: Thanks, Sarah.

12 DR. SAMPSEL: Page 50. Sorry,
13 Sepheen.

14 MS. BYRON: All right. So, this is
15 switching gears significantly from all the
16 PQIs that you guys have been discussing.
17 But this is a health plan-level measure that
18 looks at breast cancer screening in women 50
19 to 74 years of age.

20 Just some historical background
21 here. This was a measure that was endorsed
22 by NQF but it lost endorsement when it

1 became out of alignment with the U.S.
2 Preventive Services Task Force guideline.

3 Previously the task force had
4 recommended screening in 40- to 69-year-olds
5 and that was what our measure originally
6 specified.

7 And we have since updated the
8 measure to align with that 50- to 74-year
9 age range that the task force recommends.
10 And so the measure has been updated and is
11 now in the HEDIS health plan measure set as
12 a measure specifying women 50 to 74 years
13 for biennial, so every 2 year mammogram
14 screening. So we're coming back for re-
15 endorsement.

16 DR. SAMPSEL: Thank you, Sepheen.
17 And I'll turn it over to Katie to start the
18 discussion on criterion 1 and evidence.

19 MS. SELLERS: Okay, great. Yes, so
20 this is a process measure. And the evidence
21 provided is -- it's based on the U.S.
22 Preventive Services Task Force

1 recommendation. It is a level B
2 recommendation as are most cancer screening,
3 or maybe all cancer screening
4 recommendations.

5 It was -- the task force rating for
6 the quality of the evidence was fair which
7 is acceptable. It was based on seven
8 randomized controlled trials. I think
9 that's about all to say about it, about the
10 evidence.

11 DR. SAMPSEL: Comments? Questions?
12 Considerations about the evidence to support
13 this measure? Eric.

14 MR. FRANCE: Just maybe to point out
15 that it is being reviewed by the USPSTF now
16 and so we'll be maybe thinking about the
17 evidence based on their 2009 review which as
18 you said was a B rating. Moderate certainty
19 of moderate benefit.

20 And they're in the process now of
21 redoing this so either our task force or a
22 future one might want to rethink it once

1 they come up with new recommendations should
2 they show less benefit associated with the
3 evidence.

4 DR. SAMPSEL: John?

5 MR. AUERBACH: I would just ask how
6 much confusion there is in the clinical
7 community about this. Because my impression
8 is there is quite a bit of confusion about
9 what the appropriate recommendations are.

10 And so I ask that just because I
11 think that using this as a measure of
12 quality in a period of time when the
13 recommendations are changing and that there
14 is a good deal of uncertainty about what
15 appropriate care is I just think is
16 confusing for what it means.

17 DR. SAMPSEL: And I think I'd ask
18 Sepheen and Mary if you can comment.
19 Probably considerations of the MAP.

20 MS. BYRON: Yes. And I would say
21 that one of the reasons that supports having
22 the measure. You know, to be clear, the

1 measure does not penalize you for doing
2 screenings in other women.

3 So you know, the task force also has
4 a C recommendation which says it's an
5 individual decision between a woman and
6 their physician based on their individual
7 factors for the lower age groups.

8 But our measure just says that where
9 we do have evidence that is clear for the
10 50- to 74-year-olds that's where we would
11 like to see screening happen.

12 MS. BARTON: Just that I would say
13 that Sepheen and the team looked not only at
14 the U.S. Preventive Services Task Force
15 recommendation but at other clinical
16 recommendations. And where they used the
17 intersection set really where the
18 recommendations overlapped to make the
19 measure.

20 The measure is never going to
21 replace a guideline and it's not our intent
22 that people should act as though this

1 measure is a guideline. But rather as an
2 indicator of where there is a consistent
3 message from all of the recommending bodies
4 it is in this age group.

5 MS. BYRON: And I would just add one
6 more thing which is that the measurement
7 advisory panel that we did convene, we
8 always strive to keep them as multi-
9 stakeholder as possible.

10 So we had representation from
11 clinicians and oncologists but also patient
12 advocates, policymakers, women's health,
13 general internists as well to make sure that
14 we got that balance. And that has helped us
15 to develop the measure that we did.

16 DR. SAMPSEL: Marcel?

17 MR. SALIVE: So, I think even if the
18 task force is reconsidering that it's not
19 going to change its recommendation in this
20 age group. So you know, that's a highly
21 unlikely outcome. There's not a lot of new
22 evidence being generated in that age group.

1 And so that's what it would take. So, they
2 may change it in other age groups but this
3 age group is fine and I think solid and can
4 be endorsed probably.

5 MR. FRANCE: I'd just add that that
6 may not be the case. They may be moving
7 more towards a shared decision approach for
8 this kind of screening.

9 It's -- breast cancer screening in
10 women is -- when you look at the actual
11 numbers it looks like prostate cancer
12 screening in men in terms of lives saved and
13 values. Every two years.

14 Finally, I'd just clarify too that
15 cervical cancer is an A rating screening and
16 colorectal screening is an A rating
17 screening. I think the comment was made
18 that most of them would be --

19 DR. SAMPSEL: Eric, we can't hear
20 you. Can you speak?

21 MR. FRANCE: All right, I'll speak a
22 little closer. Just to clarify that the

1 colorectal screening and cervical are both
2 A-rated screening tests rather than B-rated
3 as I think Katie had mentioned. And
4 prostate is a D, against. So I would not be
5 surprised if USPSTF changes its
6 recommendations.

7 I think still our basis for today's
8 vote is on the measure as is with evidence
9 as reviewed which is the B rating and that's
10 how I'll be looking at it.

11 DR. SAMPSEL: Ron?

12 MR. BIALEK: Just a clarification.
13 So this is a screening ever. Just one
14 screening. The way it's specified is --
15 okay.

16 MS. BYRON: At least one mammogram.
17 In the two-year period.

18 MR. BIALEK: In the two-year period.

19 MS. BYRON: Yes.

20 MR. BIALEK: No, I'm just looking at
21 the measure.

22 MR. FRANCE: Yes, the measure is

1 every two years.

2 MR. BIALEK: Okay.

3 MR. FRANCE: And so it's looking
4 back in the last two years whether you were
5 screened.

6 MR. BIALEK: Which is consistent
7 with the task force.

8 DR. SAMPSEL: Okay. If there are no
9 other comments or questions about evidence
10 we'll vote on evidence and 1(a).

11 MS. ROBINSON-ECTOR: Voting is open.
12 All votes are in and voting is closed. For
13 evidence 5 voted high, 12 voted moderate, 2
14 voted low, 1 voted insufficient and zero
15 voted insufficient with exception.

16 DR. SAMPSEL: Great. Katie, were
17 there any comments regarding performance
18 gap?

19 MS. SELLERS: The performance gap
20 was pretty clear. The data -- well, what I
21 wanted to say was that the data that were
22 presented were all based on the formerly

1 recommended age group. So they were based
2 on women 40 to 74 years.

3 But given that the performance gap
4 was pretty clear. Looking at the different
5 plans the means ranged from 50 to 71
6 percent. And some of the individual plans
7 were really quite low. It looked like one
8 was even 4 percent. So, very big
9 performance gap.

10 DR. SAMPSEL: Questions or comments
11 about performance gap? We'll go to vote.

12 MS. ROBINSON-ECTOR: Voting is open.
13 All votes are in and voting is now closed.
14 For performance gap 13 voted high, 7 voted
15 moderate, zero voted low and zero voted
16 insufficient.

17 DR. SAMPSEL: And Katie, any
18 comments on priority?

19 MS. SELLERS: Yes, so as far as the
20 priority goes I think there was consensus
21 that this was a high-priority health
22 condition.

1 About the screening itself I think
2 that might be more of a moderate rating as,
3 you know, a little bit of controversy over
4 the benefit of the screening. But for the
5 most part I think the priority was moderate
6 to high.

7 DR. SAMPSEL: Discussion on
8 priority.

9 MS. ROBINSON-ECTOR: Voting is open.
10 All the votes are in and voting is now
11 closed. For high priority nine voted high,
12 nine voted moderate, two voted low and zero
13 voted insufficient.

14 DR. SAMPSEL: And Katie, if you
15 could lead us on reliability, validity,
16 scientific acceptability.

17 MS. SELLERS: Yes. So, the
18 numerator statement is women who received a
19 mammogram to screen for breast cancer. The
20 denominator is women aged 52 to 74 years as
21 of December 31 during the measurement year.

22 And then the time period for this is

1 27 months. So that's the two years plus an
2 additional three-month leeway which is used
3 in other HEDIS measures in a similar
4 fashion.

5 It has to be primary screening only,
6 not biopsies, ultrasounds or MRIs. The data
7 source is administrative claims electronic
8 clinical data. There was some confusion in
9 the workgroup around the time period but I
10 think it's pretty clearly a two-year time
11 period with an additional three-month sort
12 of leeway which is to help with pushing for
13 over-screening, just to make sure it doesn't
14 push for over-screening.

15 And then on the reliability it
16 seemed to have very high reliability measure
17 scores. They did a beta binomial test. It
18 was -- the values were 0.95 to 0.99 with a
19 very large sample. It had 1,000 different
20 plans representing over 80,000 patients.

21 DR. SAMPSEL: Questions about
22 reliability and validity? Okay.

1 MS. ROBINSON-ECTOR: Voting is open.
2 All votes are in and voting is closed. For
3 reliability 12 voted high, 8 voted moderate,
4 zero voted low and zero voted insufficient.

5 MS. SELLERS: Okay, so moving onto
6 validity. The NCQA uses a systematic
7 process for face validity testing which was
8 shown to be strong.

9 For construct validity what they did
10 was look at the correlation with colorectal
11 screening and with cervical cancer screening
12 at the plan level. And those correlations
13 were 0.7 and 0.73.

14 They did not do risk adjustment as
15 far as I could tell. The exclusions were
16 for bilateral mastectomy. There was not an
17 issue of missing data.

18 I guess one thing that I would note
19 that I think was sort of alluded to earlier
20 was that it does not allow for exclusion due
21 to patient or provider refusal. But overall
22 I think it looked like pretty high validity.

1 DR. SAMPSEL: Comments or questions?

2 Go ahead.

3 MS. ROBINSON-ECTOR: Voting is open.

4 All votes are in and voting is now closed.

5 For validity 9 voted high, 10 voted

6 moderate, 1 voted low and zero voted

7 insufficient.

8 MS. SELLERS: So for feasibility

9 these are data that are already being

10 collected and the workgroup had no concerns

11 on this.

12 DR. SAMPSEL: Committee members?

13 Okay.

14 MS. ROBINSON-ECTOR: This is for

15 feasibility and voting is open. All votes

16 are in and voting is now closed. For

17 feasibility 19 voted high, 1 voted moderate,

18 zero voted low and zero voted insufficient.

19 MS. SELLERS: So for usability and

20 use this is similar to a number of other

21 measures we've seen where there's a lot of

22 current use, it's used in health plan report

1 cards, State of Healthcare Report, Medicaid
2 Adult Core set, NCQA accreditation, Quality
3 Compass, et cetera, et cetera.

4 But the performance has been steady.
5 So I think questions about usability have to
6 do with has it been used for actual
7 improvement.

8 As far as unintended consequences I
9 think there's a potential for over-screening
10 and the consequences that go with that. But
11 again, that's with -- the three-month leeway
12 is intended to help with that so that there
13 isn't additional screening just to meet the
14 measure. I think that was about it for
15 usability and use.

16 DR. SAMPSEL: Ron?

17 MR. BIALEK: When the measure is
18 published will it be specified exactly as it
19 is on the screen without any period of time?

20 So right now it reads the percentage
21 of women 50 to 74 years of age who had a
22 mammogram to screen for breast cancer.

1 DR. SAMPSEL: Are you talking about
2 publishing in HEDIS?

3 MR. BIALEK: When this measure is
4 published by -- endorsed by us, by NQF is it
5 exactly going to appear that way without any
6 indication of the period of time.

7 So for instance, with oral health it
8 says screening within the reporting year.
9 This measure doesn't say anything about how
10 often. I know it is in the data and it's
11 taken into consideration, but the measure
12 that we're endorsing would read exactly this
13 way? Without any --

14 MS. MUNTHALI: Yes, it would read
15 exactly this way. Unless the committee
16 would like to, again, recommend to NCQA to
17 make that refinement.

18 MR. BIALEK: My concern is that when
19 John earlier said about confusion is this
20 measure articulated this way going to add to
21 confusion or help with confusion? Unless
22 one digs into what the measure says it does.

1 MS. BARTON: We're sympathetic to
2 the fact that there's clinical confusion.
3 We specify this for health plans and in fact
4 there's a volume that health plans get that
5 includes the detail of the specification for
6 how it's to be implemented.

7 I think if NQF is interested in a
8 different level of detail for this
9 particular four-line description which
10 admittedly is super high-level -- there's a
11 lot of details that are not included there -
12 - I would be delighted to work with them and
13 make sure that you have all the relevant
14 data points you want to put into your four-
15 line summary.

16 MS. MUNTALI: And this is just for
17 presentation for today. It's just a really
18 brief synopsis of what's in your submission
19 form. So I think we need to -- maybe the
20 two of us can work together. You could
21 reevaluate your submission form to make sure
22 that that's comprehensive enough and it's

1 not causing confusion when we put it out.

2 DR. SAMPSEL: Jacki.

3 MS. MOLINE: There is so much going
4 on now. I think now the breast surgeons are
5 beginning to weigh in. They've convened a
6 panel to decide what the recommendations
7 should be because there is such controversy.

8 But in many ways it shows the value
9 of the measure which is to say where are we
10 now. And how over time with the changes in
11 the professional organizations or the
12 changes in the USPSTF, how do the rates of
13 mammography change in accordance with
14 different guidelines.

15 So in fact, if anything it makes the
16 measure more valuable because it's a way --
17 it's almost a snapshot of getting a sense of
18 how do patterns change with controversy
19 and/or deferential opinions from different
20 professional organizations.

21 And it's actually -- it's a social
22 experiment in many ways to look at this. So

1 there's a way of looking at the measure in
2 that way.

3 DR. SAMPSEL: Mike?

4 MR. STOTO: I think that Ron has an
5 important point. And if we just added "in
6 the previous two years" to the end of that
7 it would simplify things quite a lot.

8 People tend to grab this and put it
9 on a figure and so on and that's an
10 important thing to do also.

11 DR. SAMPSEL: And I'll just add with
12 my health plan hat, you know, during the
13 time period that this measure had lost
14 endorsement certainly health plans didn't
15 take priority off the measure. But it was -
16 - there was an area of confusion of what do
17 we work on. And how do we move forward with
18 some of our quality improvement efforts.

19 So I think, you know, your point
20 earlier was valid, Katie, about kind of
21 questions on where are there QI efforts
22 right now.

1 And you know, we saw and I was
2 working for WellPoint at the time, so we
3 also saw different interpretations across
4 the country on which age groups to use. So
5 people have been waiting for this measure to
6 come back.

7 Not that it really ever went away,
8 but having some more of that standardization
9 around for comparability because folks were
10 starting to use just iterations of
11 unendorsed measures which didn't make the
12 field happy either. So I do think it's
13 still in heavy use and of strong interest to
14 health plans.

15 So with no other comments we'll vote
16 on usability. Oh, I'm sorry, Renee?

17 MS. FRAZIER: I just want to
18 clarify. Are we going to add the comment or
19 not? I mean, that's what I was going to --
20 and Ron said it. Are we or aren't we adding
21 that simple language in this summary format
22 so it's clear and up front what the endorsed

1 measure is?

2 DR. SAMPSEL: Right. So the
3 specification already clearly says that.
4 What we'll need to work on is on the
5 description for the NQF quality position
6 system website.

7 MS. ROBINSON-ECTOR: This is for
8 usability and voting is open. All votes are
9 in and voting is now closed. For usability
10 14 voted high, 5 voted moderate, 1 voted low
11 and zero voted insufficient information.

12 DR. SAMPSEL: Okay, other comments
13 regarding overall suitability for
14 endorsement? I think this still goes, you
15 know, this is probably where that
16 description conversation came back in. But
17 any other concerns, questions? Great, let's
18 vote.

19 MS. ROBINSON-ECTOR: For overall
20 suitability for endorsement voting is open.
21 All votes are in and voting is now closed.
22 For overall suitability for endorsement for

1 measure 2372 Breast Cancer Screening 18
2 voted yes, 2 voted no. The measure passes.

3 DR. SAMPSEL: Great. Thanks,
4 everybody, for making it through the
5 morning. And lunch is here so we're going
6 to ask that everybody get up and grab their
7 lunches.

8 We're going to reconvene at 12:30
9 and I've asked Patrick to call back in at
10 that point to continue our discussion on the
11 PQI measures.

12 (Whereupon, the foregoing matter
13 went off the record at 12:11 p.m. and went
14 back on the record at 12:36 p.m.)

15 DR. MCINERNEY: We've had hopefully
16 ample time for most of you to get most of
17 your lunch. And my understanding is that we
18 postponed a discussion on 0285 which is the
19 rate of lower extremity amputation among
20 patients with diabetes.

21 Oh, I'm sorry, public comment first.

22 MS. MUNTHALI: Cathy, can you please

1 open up the lines for members of the public
2 to make comment if they'd like?

3 OPERATOR: Yes, ma'am. At this time
4 to make a comment please press * then the
5 number 1. There are no public comments at
6 this time.

7 MS. MUNTHALI: Thank you.

8 DR. MCINERNEY: Okay, so this is on
9 page 24 of your worksheet. Did we do any
10 discussion of this at all?

11 MS. MCKANE: We began to have some
12 discussion and we went through the evidence.

13 DR. SAMPSEL: Yes, we went through
14 evidence and then we were having a
15 discussion regarding --

16 MS. MCKANE: Regarding whether toe
17 amputations are currently excluded from the
18 numerator. But they're included in the
19 Excel spreadsheet as one of the ICD-9 codes
20 that's included in the numerator. So we
21 needed to have clarification on what the
22 measure was actually -- what the actual

1 measure was.

2 DR. MCINERNEY: Are our measure
3 developers here?

4 MS. MUNTHALI: Patrick, are you on
5 the line?

6 DR. MCINERNEY: Are we expecting
7 them to join us?

8 MS. MUNTHALI: We are. He was
9 coming from a conference. I told him what
10 time but I don't think he's out of the
11 meeting yet.

12 DR. MCINERNEY: And what about the
13 other two measures that we haven't --

14 MS. MUNTHALI: They're also AHRQ.

15 DR. MCINERNEY: AHRQ. Oh, well.

16 MS. MUNTHALI: I think let's just
17 break for about 10 minutes and we'll try and
18 reach Patrick some other way. And then if
19 not we can proceed.

20 DR. MCINERNEY: All right, so should
21 we just not do anything?

22 MS. MUNTHALI: For 10 minutes.

1 DR. MCINERNEY: All right, enjoy
2 your lunch and take a little postprandial
3 nap if you'd like.

4 (Whereupon, the foregoing matter
5 went off the record at 12:39 p.m. and went
6 back on the record at 12:49 p.m.)

7 DR. MCINERNEY: Patrick is with us,
8 folks, so we're going to start on measure
9 0285 on page 24 of your measure worksheet.
10 This is the rate of lower extremity
11 amputation among patients with diabetes.

12 And the description of the measure
13 is admissions for any listed diagnosis of
14 diabetes and any listed procedure of lower
15 extremity amputation per 100,000 population
16 ages 18 and older. And it excludes any
17 listed diagnoses of traumatic lower
18 extremity amputation admissions, toe
19 amputation admission likely to be traumatic,
20 obstetric admissions and transfers from
21 other institutions.

22 And I understand that there was some

1 previous conversation about this this
2 morning and some questions were raised. And
3 could we review those questions and then
4 proceed, please?

5 MS. MCKANE: Sure. This is an
6 outcome measure and we were discussing the
7 discrepancy between the numerator as listed
8 in the description versus the numerator
9 that's described in the ICD-9 codes.
10 Because the ICD-9 codes indicate that toe
11 amputations would be included if within the
12 numerator. And the description of the
13 numerator excludes toe amputations. So we
14 wanted to have some clarification on that
15 issue from the developer.

16 DR. MCINERNEY: Patrick?

17 MR. ROMANO: Yes, can you hear me?

18 DR. MCINERNEY: Yes.

19 MR. ROMANO: Yes. So we were able
20 to clarify that. And so, this is basically
21 an idiosyncrasy in the SAS code. Suffice it
22 to say that toe amputations are excluded.

1 The brief historical perspective is
2 that in the original version of this
3 indicator toe amputations were included.
4 And subsequently based on user feedback as
5 well as empirical analysis and a second
6 round of expert panel discussion.

7 We did choose to remove toe
8 amputations in version 4.5 which is the
9 current version. But the way that was done
10 was basically by backing them out after
11 putting them in.

12 So it's a little bit confusing with
13 the technical description but the intent as
14 well as the operationalization is that they
15 are excluded. So if there's only a toe
16 amputation with nothing more proximal the
17 intent is to exclude. And that is what the
18 SAS code does.

19 DR. SAMPSEL: Thank you.

20 DR. MCINERNEY: All right, is
21 everybody comfortable with that? Yes?
22 Okay.

1 So who is going to lead the
2 discussion?

3 MS. MCKANE: I'm leading the
4 discussion.

5 DR. MCINERNEY: Oh good.

6 MS. MCKANE: And we -- I'm not
7 really sure where we left off but we did
8 talk about that there was evidence. This is
9 like the other indicators where it's an
10 outcome but there are other factors beyond -
11 - in access to medical care, or medical care
12 that could be in place such as community-
13 level factors. So it was very similar to
14 the other measures in this family.

15 And I believe that we identified
16 there is a performance gap. There is
17 evidence that the rate as described in the
18 description from the developers is
19 increasing yet that rate is not adjusted for
20 prevalence of diabetes and is not -- is per
21 100,000 of population and not among
22 diabetics. And that is something that was a

1 concern that was raised with this measure.

2 And when we look at our accounting
3 for diabetics -- among diabetics the
4 incidence of amputations is actually
5 decreasing.

6 We did note that there were gender
7 differences and age differences. Race and
8 ethnicity is not mentioned as something that
9 was measured but was based on the
10 literature. But there is definitely racial
11 and ethnic disparities.

12 We felt the priority was high. It's
13 a high-impact priority for a smaller segment
14 of the population. But the prevalence of
15 diabetes is increasing. And the measure may
16 capture people who had little interaction
17 with healthcare prior.

18 We also felt that, let's see, I
19 don't -- we also had made some other
20 comments with regard to using geocoding to
21 give them a more precise estimate validity
22 to pinpoint high-risk neighborhoods.

1 So I think that that is a summary
2 from the workgroup. Are there any more
3 comments about that?

4 I know that we had quite a
5 discussion about all of this in the call as
6 well as around these other measures as well.

7 DR. MCINERNEY: Other comments from
8 the committee members on the evidence? All
9 right. Oh, yes.

10 MR. SALIVE: So I did look into the
11 business of why the rate didn't change. I
12 don't know exactly if we ironed that out.

13 But when I looked at the national
14 data from CDC on where it's -- it is a
15 Healthy People 2010 objective to lower the
16 risk of amputations. But they do use a
17 denominator of diabetic patients.

18 And they did report that it was cut
19 in half from 1997 to 2005. So, there was --
20 that was another source of information that
21 I found.

22 And I wasn't sure if this was the

1 time but I do think harmonization with that
2 national objective would be helpful. By you
3 know, using the diabetic population as the
4 denominator. But maybe that's for now, or
5 maybe that's for later.

6 DR. MCINERNEY: I think that's a
7 good point about the harmonization. And I
8 think though we would save that for later.
9 Are we ready then to -- oh, sorry. Mike?

10 MR. STOTO: Is having the
11 denominator only be people with diabetes
12 more important for this one than for the
13 other diabetes measures? I'm wondering why
14 this is coming up now? Why is that?

15 DR. MCINERNEY: That's a good
16 question.

17 MR. SALIVE: There are pros and cons
18 to using the diabetes persons as the
19 denominator. And so Census data is very
20 widely available. The prevalence of
21 diabetes does seem to change partly because
22 a lot of it is undiagnosed. And so I think

1 there is a trend towards greater diagnosis
2 of diabetes now than in the past.

3 As well as a change in strictly
4 speaking the amount of diabetes. So, I
5 think getting -- so getting small area
6 diabetes estimates is the tricky part.

7 MR. STOTO: But that -- everything
8 you said also applies to all the diabetes
9 measures that we've been talking about.
10 Presumably. I don't understand why this one
11 is different from the other three with
12 respect to what the denominator should be.

13 MR. SALIVE: I feel strongly that it
14 should be for this one.

15 MS. MCKANE: I think it was
16 something we talked about in the call if I
17 remember because we also -- for all the
18 measures, particularly the longer-term ones.

19 But I think that one of the
20 takeaways that we were talking about is the
21 importance of having a population level, the
22 population, and then also trying to

1 attribute it to the -- among the cohort that
2 actually has diabetes.

3 And the tricky part is actually
4 trying to define the number of patients that
5 have -- or to reach a denominator that is
6 meaningful for patients with diabetes was
7 the issue that I think we kind of bumped up
8 against.

9 And it is something I thought in the
10 specs that these could be analyzed in both
11 ways, that that was not -- for any of them,
12 for any of the measures.

13 DR. MCINERNEY: So I think for
14 consistency's sake we should stick with what
15 we've been doing and that is for the entire
16 population.

17 MR. STOTO: I think that having one
18 with a different denominator than the rest
19 would be far more confusing.

20 DR. MCINERNEY: Right. Good. Okay,
21 any further discussion on evidence? All
22 right. Let's vote on evidence, please.

1 MR. ROMANO: This is Patrick. Could
2 I say something?

3 DR. MCINERNEY: Sure, Patrick.

4 MR. ROMANO: Yes, just two quick
5 comments. One is that AHRQ has been doing
6 empirical work over the last year to try to
7 implement a small area estimation procedure
8 for diabetes prevalence using the BRFSS
9 data, the Behavioral Risk Factor
10 Surveillance System data that are available
11 from CDC.

12 The practical issue is that we need
13 estimates at the county level and we need
14 estimates also that can be drilled down to
15 age and gender subgroups within small areas.

16 So, anyway, the empirical work is
17 ongoing. And so we may come back to NQF,
18 AHRQ may come back to NQF with a recommended
19 implementation procedure. But it's not
20 technically straightforward because of the
21 desire to be able to offer these rates, not
22 just at the state level where it would be

1 easy, but at the county level or the MSA
2 level where it gets trickier.

3 MR. AUERBACH: I would just say that
4 the dilemma in terms of the database that
5 Patrick's talking about, it's self-reported
6 random digit-dial telephone calls asking
7 people if they're diabetic. And so it's a
8 really inexact measure.

9 So it's often what gets used but I
10 think it doesn't account for undercounting
11 or under-diagnosis. And it also doesn't
12 count -- it's not done in multiple
13 languages. There's a lot of obstacles to
14 using that as a reliable data source.

15 So I think that just having a
16 denominator of diabetics is quite
17 challenging.

18 MR. ROMANO: Yes. And the other
19 point I wanted to make is with reference to
20 the time range, just so we're talking about
21 parallel time ranges.

22 Actually, if you take the AHRQ

1 indicator back to 2000 there has been a
2 significant drop during the period from 2000
3 to 2008. It's just that the rates have been
4 flat since 2008. So between 2000 and 2008
5 there was approximately a one-third drop
6 even according to the AHRQ indicator in
7 lower extremity amputations for diabetes per
8 100,000 persons.

9 MR. BIALEK: Having absolutely no
10 knowledge or expertise in this topic area I
11 wanted to ask a question of those who do.

12 Is there anything that's lost by
13 these changes that are being made in terms
14 of -- we're capturing events, right? Not
15 people. And is there any problem with that?
16 Any concern about just capturing events, not
17 people.

18 Removing the toe amputation sounded
19 like that reduces that problem but does it
20 reduce it enough? Because I think we want
21 to be capturing people versus just events.

22 DR. MCINERNEY: I mean you're

1 concerned that the same person could come in
2 for two or three different amputations at
3 two or three different levels.

4 (Laughter)

5 MR. BIALEK: Well, and there's parts
6 of -- I mean, I just don't know enough to --
7 because to make a change we're talking about
8 changes to individuals, right?

9 So is it a problem? It may not be.
10 I just am asking the question.

11 DR. MCINERNEY: Patrick, can you
12 answer that, please?

13 MR. ROMANO: Well, it is still
14 potentially an issue.

15 Of course, one might argue that to
16 the extent to which the left leg has
17 amputation and the right leg later, that
18 those perhaps should count as separate
19 events. So it depends whether the right
20 unit of analysis is the person or the
21 extremity. And we haven't resolved that
22 question.

1 But we do think that by removing the
2 toes it removes the most obvious
3 manifestation of this problem of non-
4 independence.

5 DR. MCINERNEY: Thank you. Are we
6 ready to take the vote then on the evidence?
7 Importance to measure evidence? All right,
8 please, Kaitlynn.

9 MS. ROBINSON-ECTOR: This is for
10 evidence and voting is open. I think we're
11 waiting for one more vote. All votes are in
12 and voting is now closed.

13 For evidence 18 voted yes and zero
14 voted no.

15 DR. MCINERNEY: Okay, good. So then
16 I think we also -- we did have some
17 discussion about the performance gap in the
18 priority in your presentation.

19 Do we have any further discussion on
20 performance gap or are we ready to vote on
21 that now?

22 It looks like we're ready to vote on

1 performance gap, please.

2 MS. ROBINSON-ECTOR: This is for
3 performance gap and voting is open. All
4 votes are in and voting is now closed. For
5 performance gap 13 voted high, 5 voted
6 moderate, zero voted low and zero voted
7 insufficient.

8 DR. MCINERNEY: Okay, moving along
9 now, priority. High-priority. Any further
10 discussion on priority?

11 Okay, then let's vote, please.
12 Thanks.

13 MS. ROBINSON-ECTOR: This is for
14 high priority and voting is open. All votes
15 are in and voting is now closed. For high
16 priority 15 voted high, 2 voted moderate, 1
17 voted low and zero voted insufficient.

18 DR. MCINERNEY: Okay, good. Let's
19 move now to discussion of reliability and
20 validity, please.

21 MS. MCKANE: The numerator and
22 denominator are well defined. The

1 denominator is from the Census data. And
2 the data source for the numerator is the
3 discharge data that we've been talking
4 about.

5 The measure was tested for
6 reliability at the measure score level. And
7 overall the measure was rated as moderately
8 reliable by the developers. And it seemed
9 to be it was more reliable for larger
10 population areas and very much consistent
11 with the other ones.

12 As far as -- are we talking about
13 validity too? So, the specifications align
14 with the evidence. The measure was tested
15 for validity at the measure score level.
16 And they did empirical validity testing.
17 And I think we rated this as moderate or
18 moderately high.

19 We did have some -- there was a
20 comment from -- that was submitted from the
21 public that the -- from the Armstrong
22 Institute for Patient Safety and Quality who

1 questioned whether this was the correct
2 denominator which we were discussing. But
3 also made the comment both the numerator and
4 the denominator are easy to collect.

5 MR. AUERBACH: Are we talking about
6 reliability and validity at this point, or
7 just reliability?

8 Well, I guess -- this is in the
9 spirit of -- for who's often asked this
10 question. I guess I just wanted to make
11 sure that we are somehow going to capture in
12 the commentary on this the confusion one
13 could have in looking at hospitalizations
14 and rates appearing to go up while we think
15 that they've actually gone down if we have
16 the denominator, an accurate denominator
17 with diabetes.

18 Because again, if you're simply
19 looking at that and you're using it for
20 quality standards it looks like you're
21 failing because the numbers are going up.
22 And so I think it just requires some

1 crafting of language to help people to
2 interpret what it means.

3 If the story is we're doing a really
4 good job even though the number is going up
5 and that insurers and providers should be
6 aware of that I think crafting that language
7 is important.

8 MR. VALDEZ: Could the developer
9 just explain to me again, I'm not sure I
10 understood why transfers from other
11 facilities were being excluded from this
12 measure?

13 MR. ROMANO: That would be to avoid
14 double-counting essentially of the same
15 hospitalization. When the hospitalization -
16 - into two different facilities.

17 MR. VALDEZ: But you're not looking
18 at the hospitalization, you're looking at
19 the amputation.

20 MR. ROMANO: Right. So, your point
21 is that --

22 MR. VALDEZ: -- take the leg off

1 twice.

2 MR. ROMANO: Yes.

3 MR. AUERBACH: It's the question of
4 whether the measure of quality is the
5 ambulatory care or the nursing home care I
6 think that determines it.

7 MR. VALDEZ: Right, but we're not
8 looking at care necessarily. Otherwise we'd
9 go to the diabetic as the denominator.

10 If we're looking at amputations then
11 it shouldn't really matter where the source
12 of the patient is.

13 MS. MCKANE: Right, and I had the
14 same question for the developer about the
15 exclusion of nursing home patients. And the
16 rationale provided was that they are -- they
17 should have -- be surrounded by care.

18 And the reality is that may or may
19 not be true and for the same reason, that
20 part of the population within that area is
21 another amputation that's not being counted.

22 MR. ROMANO: Yes. Well, I think

1 that the point, certainly we accept the
2 point reference to transfer from another
3 hospital. It's quite possible that that
4 exclusion should be revisited.

5 Because as you're saying if we're
6 only counting the hospitalization at which
7 the amputation occurred there isn't any
8 clear reason to exclude patients based on
9 whether they were admitted to another
10 hospital first.

11 In the case of skilled nursing care
12 that is an across-the-board exclusion
13 because these indicators have been viewed as
14 ambulatory care-sensitive conditions or
15 indicators. And by definition if somebody
16 is a long-term care resident of a skilled
17 nursing facility they're not receiving
18 ambulatory care through the same healthcare
19 structures as someone who's in the
20 community.

21 But, so those two issues are
22 slightly different and I think the first one

1 certainly should be reevaluated. And we can
2 put that on our to-do list to check what the
3 implications of dropping that exclusion
4 would be.

5 The second related to SNF is a
6 broader conceptual issue that I think
7 underlies all of these indicators. So, I'm
8 not sure I see that changing without much
9 broader discussion.

10 MS. MCKANE: Thank you. I was just
11 wondering if in the future are you planning
12 to measure this for the elderly population?
13 Or do you actually have a measure?

14 MR. ROMANO: There is no AHRQ
15 measure specifically for the long-term care
16 population. I think CMS obviously has other
17 measure development programs that are geared
18 towards the long-term care population
19 through the Oasis data. But I don't think
20 there's an indicator of this type in the CMS
21 set. But certainly that's a topic that
22 could be brought into harmonization

1 discussions with CMS.

2 DR. MCINERNEY: Okay. I think we're
3 ready to vote on reliability, please. Thank
4 you.

5 MS. ROBINSON-ECTOR: This is for
6 reliability and voting is open. All votes
7 are in and voting is now closed. For
8 reliability 6 voted high, 12 voted moderate,
9 zero voted low and zero voted insufficient.

10 DR. MCINERNEY: Validity. Do we
11 have any further discussion about validity?
12 All right, hearing none let's go ahead and
13 vote on validity, please.

14 MS. ROBINSON-ECTOR: This is for
15 validity and voting is open. One vote is
16 still out. All votes are in and voting is
17 now closed. For validity 5 voted high, 11
18 voted moderate, 2 voted low and zero voted
19 insufficient.

20 DR. MCINERNEY: Some discussion on
21 feasibility, please.

22 MR. ROMANO: Can I ask a

1 clarification question of NQF staff?

2 So, if we were to recommend
3 implementation, for example, of dropping the
4 hospital transfer exclusion based on the
5 discussion here what would be the process
6 for doing that? Would that have to come
7 back to this committee, or would that be
8 done at a staff level?

9 MS. MUNTHALI: It would come back to
10 the committee and we'd ask the committee to
11 re-look at it after comment. And then vote
12 over a phone call.

13 MR. ROMANO: Okay, thank you.

14 MR. VENKATESH: Patrick, this is
15 Arjun. If we're going to look at that I
16 would only ask if it's possible to do an
17 analysis where you look at hospitalizations
18 in the previous or following day from the
19 hospitalizations that are being currently
20 excluded because of the transfer.

21 Because we've done this for vascular
22 surgeries before and find that often there

1 are two hospitalizations with the principal
2 discharge diagnosis of the vascular surgery
3 even though the procedure was only done
4 during one of those hospitalizations.

5 So we need to check like that to
6 make sure we're not creating some unintended
7 counts.

8 MR. ROMANO: Thank you.

9 MS. MCKANE: Okay, move onto
10 feasibility. This is very similar to all
11 the others. This uses electronic hospital
12 claims and Census population denominator.

13 The data are generated during care
14 and coded. And it seems to be the data
15 collection are implemented --

16 DR. SAMPSEL: Patricia, can you
17 speak closer to your microphone?

18 MS. MCKANE: Oh, I'm sorry. The
19 feasibility we felt was -- we felt was
20 pretty high.

21 We did have concerns about the fact
22 that race and ethnicity data aren't

1 collected in this data source. And we do
2 know there are disparities. But other than
3 that that was -- electronic medical claims
4 data.

5 DR. MCINERNEY: Further discussion
6 of feasibility? Let's vote, please.

7 MS. ROBINSON-ECTOR: This is for
8 feasibility and voting is open. All votes
9 are in and voting is now closed. For
10 feasibility 13 voted high, 5 voted moderate,
11 zero voted low and zero voted insufficient.

12 DR. MCINERNEY: Usability, please.

13 MS. MCKANE: It's widely used by
14 DHHS, AHRQ, CMS and numerous states. So we
15 don't really have many additional comments
16 regarding the usability.

17 DR. MCINERNEY: Any further
18 discussion? Okay, let's vote on usability,
19 please.

20 MS. ROBINSON-ECTOR: This is for
21 usability and voting is open. There's one
22 vote out. We're still missing that vote.

1 All votes are in and voting is now closed.

2 For usability 14 voted high, 4 voted
3 moderate, zero voted low and zero voted
4 insufficient information.

5 DR. MCINERNEY: Okay, we're ready
6 for a discussion on overall suitability for
7 endorsement. Any further discussion? All
8 right, let's vote, please.

9 MS. ROBINSON-ECTOR: This is for
10 overall suitability for endorsement and
11 voting is open. One vote is missing. All
12 votes are in and voting is now closed.

13 For overall suitability for
14 endorsement measure 0285 Rate of Lower-
15 Extremity Amputation Among Patients with
16 Diabetes (PQI 16) 15 voted yes, 3 voted no.
17 The measure passes.

18 DR. MCINERNEY: Very good. Down to
19 two more.

20 Now, the discussion I believe this
21 morning was to do 0280, dehydration first.
22 All right. That's on page 14. And the

1 description of this measure, it's admissions
2 with a principal diagnosis of dehydration
3 per 100,000 population ages 18 years and
4 older. And it excludes obstetric admissions
5 and transfers from other institutions.

6 Let's see, who is going to lead this
7 discussion?

8 MR. VENKATESH: That's me. Okay.
9 So this is very similar to all the other
10 measures with respect to its denominator.
11 The difference here is it's trying to look
12 at inpatient admissions for what is -- while
13 the title says dehydration it's really
14 composed of a set of codes associated with
15 dehydration as well as adult
16 gastroenteritis.

17 And so some of this measure overlaps
18 with yesterday's pediatric measure on
19 gastroenteritis but not entirely. Just
20 think of it as kind of including that as
21 well.

22 And so in general I guess, and I

1 mentioned this to Pam when she was here
2 before, my view is that this measure may be
3 one that we should think about retirement
4 in. Because since this measure was
5 developed in the mid-two thousands the
6 healthcare system has evolved.

7 And I'm not sure this is either
8 really measuring what we want to be
9 measuring and what it is measuring may not
10 be particularly helpful or useful.

11 And so the background I'll give to
12 that is that over the course of the last 506
13 years dehydration has changed for a couple
14 of years. One is that the coding of it has
15 simply changed. So even though the same
16 care processes might be occurring a lot more
17 happens in observation services. It's the
18 same hospital bed, same everything. The
19 only difference is that it's billed as an
20 observation visit.

21 The other thing that's changed is
22 also the care has changed and become more

1 ambulatory. People are able to get IV
2 fluids in the ambulatory setting. It's
3 moved more towards the emergency department
4 or an actual observation setting.

5 And so hospitalization for
6 dehydration as a whole is down and reflects
7 a set of people that may not necessarily be
8 the preventable dehydration. So with that
9 background I'll kind of go through I guess
10 each section.

11 For evidence this is an outcome
12 measure similar to the others. I think it's
13 important to think about whether there's a
14 process-outcome linkage. And in this case
15 the original application notes that support
16 for fluid intake by high-risk individuals,
17 those are people with cognitive or
18 psychiatric needs, older age, comorbid
19 illness, high-risk medications, could with
20 additional support potentially have a
21 preventable hospitalization.

22 And then they also said that a

1 community-level process that could
2 potentially improve this is air conditioners
3 during the summer heat.

4 The challenge is that there's not a
5 lot of evidence base that suggests that
6 these various processes actually reduce the
7 hospitalization. But I actually think
8 there's some face validity, a feeling that
9 some dehydration hospitalizations are
10 preventable.

11 They cite four clinical guidelines.
12 The clinical guidelines that are cited are
13 all level 4 or level 5 evidence, so non-
14 experimental studies or expert consensus
15 that are largely about how to -- from the
16 nursing guidelines on how to manage
17 dehydration in the geriatric population.

18 Those reflect possible processes
19 that could improve dehydration care, but
20 again, they're not linked to the outcome.
21 So to me the clinical guidelines shouldn't
22 really affect how we rate the evidence here.

1 So, ultimately where I left kind of
2 that initial evidence measure was kind of as
3 moderate. And that's largely based on the
4 fact that it seems like there's probably
5 some face belief to the fact that many
6 dehydration hospitalizations can be moved to
7 the outpatient setting.

8 That said, if we're very restrictive
9 when we think about the way they've
10 described the outcome which is inpatient
11 hospitalizations for dehydration they may be
12 much less preventable. These are people
13 that likely have more comorbid illness and a
14 variety of other things going on and so it
15 may not be as applicable.

16 Should I go all the way through
17 evidence or stop there? I think we stop
18 there, is that right? Okay. So we'll do
19 gap and opportunity for improvement later,
20 right?

21 MR. FRANCE: Arjun, I'm curious
22 about process here with the outcome as the

1 measure. Is it the pass/no-pass of the
2 algorithm? Or is it down in the process
3 where you're giving it sort of a
4 low/moderate/high view?

5 MR. VENKATESH: No, it's not an
6 outcome measure. So it's still in that top
7 category.

8 The difference is that when you have
9 an outcome measure we're also asked to think
10 about whether or not there's evidence to
11 support that processes can change the
12 outcome. And I think there was evidence
13 that processes can change emergency
14 department use observation use for
15 dehydration.

16 For inpatient hospitalizations there
17 is evidence as well, some that's older, not
18 really reflective I think as much of how
19 care is delivered now.

20 DR. MCINERNEY: Patrick, would you
21 like to comment on Arjun's presentation,
22 please? Patrick?

1 MR. ROMANO: Yes, sorry. I think
2 they're valid points. I'm not sure what Pam
3 said when she was there in person, but
4 certainly there has been a shift towards
5 observation care and ED management of these
6 patients with dehydration.

7 The question is it has perhaps
8 changed the meaning of the indicator. Is it
9 -- does that mean it's time to retire it?
10 That's a little harder to say because it
11 depends on your perspective on whether you
12 think it's good to continue to encourage
13 this move towards avoiding inpatient stays
14 for patients with mild to moderate
15 dehydration.

16 MR. CARILLO: Just a couple of
17 points. Isn't the fact that hydration in an
18 ambulatory setting may forestall or inhibit
19 the admission, isn't that a measure of good
20 quality care in the ambulatory sector?

21 And also, historically, for decades
22 the EDs have hydrated you to try to prevent

1 an admission. So, I don't really see that
2 there is a historical change that would make
3 us go in the direction of dropping this.

4 MR. VENKATESH: So I think part of
5 their historical change there is more driven
6 by a change in payment policy than it is by
7 massive change in care. There's certainly
8 been a change in care where you can do much
9 more rehydration in the ambulatory setting
10 via other things.

11 But it's more payment policy. We've
12 essentially in five years in both not just
13 the Medicare population which is a lot of
14 people are thinking about that role, but in
15 the commercial population said that
16 hospitalization for dehydration will be
17 billed as observation.

18 And so what that means is in the
19 data that we then look at, in the HCUP data
20 that's used for the indicator or in anything
21 that's based on inpatient claims you don't
22 capture those.

1 And I'm not saying that's a bad
2 thing. I'm with the Patrick in the sense
3 that you could say, okay hey, measuring this
4 as an inpatient hospitalization if we want
5 to help continue to promote these going into
6 observation then that's fine except that I
7 don't think that this measure is going to
8 drive people to move it to observation. I
9 think that's purely based on payment policy.
10 When an insurer or Medicare says hey, that's
11 observation, then it's going to get billed
12 as observation.

13 And so that's what's happened.
14 That's why there's such a rapid change in
15 five years, it's just the payment policy
16 changed. And the payment policy made it
17 unmeasurable in inpatient data.

18 MR. CARILLO: But the issue of
19 observation applies to every measure in the
20 book because that's happening across the
21 board. So I don't see how that happening in
22 this particular measure gives it any less

1 credence.

2 MR. VENKATESH: So I think it's that
3 some of these diagnoses are more sensitive
4 to observation than others. And so many of
5 these, you know, some of the diabetes ones
6 will still be frequently billed as a full
7 inpatient stay. And so the degree of the
8 change is less. It certainly applies to all
9 of them.

10 I think you can see it in this one
11 in the data because the rate has dropped by
12 40 percent in five years. And so I think
13 everybody could when they see that say that
14 it's really unlikely that the amount of
15 dehydration at the county level dropped 40
16 percent in five years. These other measures
17 are changing at much smaller numbers than
18 that.

19 And so I think that's why the
20 difference with this indicator, the other
21 ones is the change in the payment policy has
22 actually made the indicator not as reliable

1 or valid versus I think that the indicator
2 carries more meaning for some of the others.

3 MR. CARILLO: But asthma, pediatric
4 asthma, I mean that certainly has the same
5 trend.

6 DR. SAMPSEL: I want to tease out a
7 little bit from other members of the group
8 to react to that and the concept of is this
9 a measure that there may be or should be a
10 consideration of a recommendation for
11 retirement.

12 MR. SALIVE: So, I guess I would say
13 that if it dropped 40 percent that's good,
14 but I mean, you know, you're not the only
15 payer. This is not the only, you know.
16 There's still room for this to have some
17 movement in the future. So I think it's a
18 bit premature to recommend that. I don't
19 see why we have to judge that.

20 I mean, it's like maybe it will go
21 down to zero. But maybe something else will
22 come up. I don't know. I think it's, you

1 know, it's a reasonable measure. There's a
2 lot of measures. And I think -- I don't see
3 a compelling reason to do it now.

4 MR. STOTO: I want to support Arjun
5 on this one. From what I've heard you say
6 it strikes me that the change that we see
7 probably is due to changes in billing rather
8 than changes in care, or risk, or anything
9 having to do with the health of people.

10 And if we're seeing that over time
11 we're probably seeing apparent differences
12 across geographical areas that also aren't
13 factual as well. And so if we have a
14 measure that is picking up more changes in
15 billing rather than changes in care that's
16 not a good measure from what I can see.

17 DR. MCINERNEY: However, could one
18 argue that the changes in billing have
19 pretty much taken place by now and there
20 won't be that much more change in billing
21 from now on? And so that therefore this
22 still could be a reasonable measure.

1 MR. STOTO: I have no idea.

2 MR. VENKATESH: I think that
3 question then to the committee is if we
4 think that's the case then is a measure of
5 inpatient hospitalizations for dehydration
6 something that we think is a good prevention
7 quality indicator for a community.

8 Because I think the population of
9 people who have inpatient hospitalizations
10 for dehydration are probably different than
11 some of the people we're thinking about in
12 our head who could otherwise be managed in
13 ambulatory settings, or who other forms of
14 hydration could prevent hospitalization.
15 It's a different pool of people.

16 DR. MCINERNEY: Okay. So I think we
17 have some -- we've had some significant
18 discussion. I think it's now time to vote
19 and let's see -- oh, somebody else has
20 something.

21 MR. FRANCE: Just a quick support of
22 what Arjun just said. So, while Mike was

1 talking about the billing I think it's more
2 compelling to talk about who's actually in
3 the hospital today for a diagnosis of
4 dehydration and are those cases that could
5 have been prevented had they been taken care
6 of differently or had they the health system
7 infrastructure in place to manage them.

8 And Arjun's already mentioned that
9 they're different. They're not the classic,
10 I'm dehydrated, I go to the hospital. To
11 prevent that as a monitoring in the county
12 of how well we're doing in our system.

13 So I don't know that I have enough
14 information to truly follow through with
15 your description that these people are
16 significantly different. So maybe that's
17 the one piece that would be interesting to
18 understand a little bit better.

19 MR. STOTO: To me this is actually a
20 validity issue rather than an importance. I
21 don't think the importance of dehydration
22 has changed. It just strikes me from what

1 I've heard that this measure is not really
2 picking up what actually is happening.

3 MR. CARILLO: The fact that there's
4 oral rehydration and more IV treatment in
5 the ambulatory does reflect good ambulatory
6 care. So, I think that that's -- goes in
7 line with what this measure is supposed to
8 show.

9 MR. ROMANO: This is Patrick.

10 DR. MCINERNEY: Go ahead.

11 MR. ROMANO: There are data from
12 some of the states participating in the HCUP
13 program related to observation stays. And
14 Pam may be able to comment further on that
15 when she's back with us.

16 So, I'm not sure exactly if AHRQ has
17 looked empirically at if there's a clear
18 substitution effect between inpatient stays
19 and observation stays. But we could
20 potentially find some data on that question.

21 The other thing just in general
22 context there are two PQIs that have not

1 been brought to NQF for endorsement
2 precisely because they've dropped about 70
3 to 80 on or more because of changes in
4 practice, specifically admissions for
5 hypertension and admissions for angina
6 without procedure.

7 Those two PQIs have not been brought
8 to NQF for endorsement. They've been
9 discussed for retirement because of the
10 magnitude of the drop.

11 So, this kind of 40 percent drop is
12 not yet of the magnitude where we would
13 ordinarily recommend retirement. But we
14 appreciate the discussion of the question.

15 DR. MCINERNEY: Thank you. Okay, I
16 think we're ready to vote now on evidence.
17 Please, Kaitlynn.

18 MS. ROBINSON-ECTOR: Voting is open.
19 All the votes are in and voting is closed.
20 For evidence 15 voted yes and 13 voted no.

21 DR. MCINERNEY: Three voted no.

22 MS. ROBINSON-ECTOR: Three, sorry.

1 DR. MCINERNEY: Okay, good. How
2 about performance gap, please.

3 MR. VENKATESH: I would just say
4 that -- so the main data here shows that
5 there is still persistent variation between
6 counties. But like I said, there was a 40
7 percent or so reduction between that five-
8 year period.

9 And since we don't -- it's kind of
10 the discussion Jason brought up earlier.
11 You know, what's the right way. At what
12 point have you improved? I don't know.

13 But my guess is that that's not that
14 there was substantial improvement over that
15 time and simply just billing change. And so
16 at the end of the day I think I'm kind of
17 left with, okay, there's variation between
18 counties. I don't know how much improvement
19 we've had or not in that time period.

20 And there is also -- sorry, there
21 are disparities. And so actually I think at
22 the end we kind of just left this at

1 moderate. Given that older adults are at
2 higher risk there's been declines across all
3 races but less so for Blacks as well as
4 decline across all incomes but less so for
5 lower-income areas.

6 DR. MCINERNEY: Thank you. Further
7 discussion on that? Okay, let's vote on
8 performance gap, please.

9 MS. ROBINSON-ECTOR: This is for
10 performance gap and voting is open. Three
11 votes are out. Three votes are still
12 missing. One vote was missing.

13 So, 6 voted for high, 12 voted for
14 moderate and 1 voted for insufficient.

15 DR. MCINERNEY: Okay. Some
16 discussion about priority.

17 MR. VENKATESH: Dehydration is
18 something that has fairly high frequency,
19 carries some associated morbidity, a little
20 bit more mortality, but it's also not
21 necessarily a condition that's listed in the
22 high-impact conditions of the HHS list or

1 National Quality Strategy and other major
2 national priorities. So I kind of left it
3 at something probably around moderate.

4 DR. MCINERNEY: Thank you. Any
5 further? Mike? Okay, let's vote on
6 priority, please.

7 MS. ROBINSON-ECTOR: Voting is open.
8 All votes are in and voting is closed. For
9 high priority 4 voted high, 14 voted
10 moderate, 1 voted low.

11 DR. MCINERNEY: All right, thank
12 you. Now we can get to the reliability and
13 validity discussions, please.

14 MR. VENKATESH: So, the numerator of
15 this measure is -- it was included above. I
16 guess we can discuss it within validity.
17 So, reliability.

18 There's two forms of reliability
19 testing. They can either test data elements
20 or the score similar to all other measures.
21 The score has been what's tested.

22 In this case though I think that

1 data element reliability may be more -- is
2 something that's also important. And the
3 reason is that for a lot of the other PQIs,
4 the diagnosis codes have fairly good
5 fidelity to what's being measured. So an
6 asthma code means it's asthma.

7 The challenge with dehydration is
8 that it's vague and ambiguous and it's
9 assigned at hospital discharge. So
10 regardless of how long the patient was in
11 the hospital, one day, three days, seven
12 days, it's dehydration on the way out the
13 door looking back. And so as a result it's
14 much more difficult to say that that was the
15 reason the person was hospitalized in the
16 first place.

17 And there's codes for things
18 alternatively you could think of that
19 patients who are dehydrated would get
20 hospitalized for. There's a set of codes
21 around weakness and malaise, for example,
22 that would often end up there.

1 And so, as a result, I'm not exactly
2 sure of the universe of dehydration, how
3 much this measure captures. They haven't
4 done any chart validation to say what that
5 would be. And so I think there's a little
6 bit of a reliability concern that comes from
7 that.

8 My guess is that this is just not
9 capturing the universe. It's capturing a
10 smaller subset.

11 And then otherwise I thought the
12 reliability testing with respect to the
13 score itself was really good. It's similar
14 to what's been done before. The signal-to-
15 noise ratio was also very similar. And kind
16 of similar to other ones as well.

17 Larger areas seem to be probably
18 measured with a little bit more reliability
19 than smaller areas.

20 DR. MCINERNEY: Thank you, Arjun.
21 Any other discussion? Yes.

22 MR. FRANCE: Just clarifying. With

1 principal diagnosis as dehydration do you
2 still have that concern about discharge?

3 MR. VENKATESH: Yes. So principal
4 diagnosis is not the admitting diagnosis,
5 it's the discharge diagnosis.

6 And so it's fine if you think that
7 the admitting diagnosis is pretty close to
8 the discharge diagnosis which in the case of
9 a lot of these things is going to be very
10 close. Like amputation I'm sure is very
11 tight. Things like asthma, very close.

12 In the case of dehydration it's
13 being assigned by kind of the coder and the
14 provider at the end on the way out the door.
15 It may be very different than what
16 originally happened kind of up front.

17 So you could see a patient with CHF
18 who is on Lasix, over-diuresed and gets
19 dehydrated and gets hospitalized. Are they
20 hospitalized for dehydration or their CHF?
21 On the way out the door the principal
22 discharge diagnosis could be dehydration and

1 we would be capturing then something around
2 their ambulatory care of their medications.

3 But more likely than not it's going
4 to be a CHF-related diagnosis on the way out
5 the door. And so those types of patients
6 would not be captured.

7 Similarly, the other population that
8 would not be captured are cancer patients
9 who may frequently be admitted for
10 dehydration but will leave the hospital with
11 a discharge diagnosis around their cancer
12 and therefore not captured by the measure.

13 MR. SALIVE: So, I guess I'm not so
14 concerned about CHF being missed because I
15 believe that is a different issue, being out
16 of tune on their cardiac meds.

17 I appreciate the point but I do
18 think that there are a number of other
19 diagnoses listed in this paperwork about,
20 you know, that do make your point a little
21 bit better perhaps that viral
22 gastroenteritis, they figure out exactly

1 which one it is and that's the principal
2 diagnosis. But that's still included here.

3 A lot of kidney disease where they
4 become dehydrated from their kidney disease.
5 I think there's a pretty long list of
6 diagnoses here. It's not purely dehydration
7 codes. So, I'm pretty happy with this list
8 and I have no concern.

9 MR. STOTO: I don't know anything
10 about the subject other than I've heard just
11 in the last few minutes. But it strikes me
12 that this situation was quite likely that a
13 patient in one location would be treated
14 very differently from a patient in another
15 location with respect to how the coding is
16 done. And that -- which is a reliability
17 problem for comparisons. It's probably true
18 over time too. It sounds like there's a
19 number of somewhat arbitrary decisions that
20 have to be made but can be made in different
21 ways in different hospitals and so on that
22 may make it difficult to compare the results

1 that come out.

2 MS. MOLINE: With respect to the
3 cancer that had been one of my initial
4 concerns. But when you look at it again it
5 can be a secondary diagnosis of dehydration.

6 And I've actually been looking at a
7 number of medical records that I've been
8 reviewing and looking at the nosologist
9 which I have to say is one of my favorite
10 words of all time. To see if they actually
11 did.

12 Because these were folks who were
13 receiving chemotherapy and virtually all of
14 them did have that. Now, this is total
15 anecdote and you don't make a measure based
16 on anecdote. But they are going to be
17 looking for those words because they'll get
18 more payment.

19 So, when I first looked at this I
20 was very concerned that they were going to
21 be missing if it had to be the primary
22 diagnosis. But with the secondary

1 diagnosis, all the complications for all the
2 other medical problems, I felt like the
3 coders are going to be looking at this
4 because it is going to increase the
5 reimbursement.

6 And it is a fairly easy thing to
7 see. If the medical record from the ER says
8 dehydration then they're going to put it in
9 there even if it wasn't the final discharge
10 diagnosis.

11 MR. VENKATESH: Actually, Patrick,
12 can we ask you, is that true? That any
13 patient with a secondary diagnosis of
14 dehydration regardless of where it falls on
15 the secondary lines is counted? Or is it
16 only if they have one of those other primary
17 principal diagnoses?

18 DR. SAMPSEL: Actually Patrick
19 stepped away. And so Carol from AHRQ -- or
20 Patrick, are you there?

21 MR. ROMANO: Yes, I am. I was about
22 to step away.

1 Yes, I think that the latter part of
2 your assessment is true. That you could
3 posit a scenario under which appointment had
4 a principal diagnosis of cancer and a
5 secondary diagnosis of dehydration where
6 they weren't counted. So that could happen.

7 I think that scenario is relatively
8 unlikely because the coding rules are pretty
9 clear that nobody wants hospitals to be
10 billing for cancer care if what they're
11 really doing is treating dehydration.

12 So, in most cases coding rules would
13 require the dehydration to be principal and
14 the cancer to be secondary, in which case it
15 would be captured.

16 The exception would be, for example,
17 a patient who was having chemotherapy and
18 had chemotherapy-induced vomiting and then
19 got dehydration from that. So in that case
20 the dehydration would be attributed to the
21 cancer and the treatment of the cancer. The
22 cancer could still end up as the principal

1 diagnosis and it would be missed.

2 But that's a different situation
3 from, for example, a patient who just
4 happens to have cancer who experiences
5 dehydration as a result of outpatient
6 issues. Those patients generally would be
7 captured.

8 So it depends on whether the
9 dehydration is actually attributed to the
10 cancer and the cancer treatment itself, or
11 whether the cancer is an incidental
12 diagnosis. Does that make sense?

13 So we would potentially be missing
14 chemotherapy-induced vomiting is the bottom
15 line if people are concerned about that.

16 DR. MCINERNEY: Marcel? No. Okay,
17 are we ready to vote on reliability?

18 MS. ROBINSON-ECTOR: Vote is open.
19 All votes are in and voting is now closed.
20 Three voted high, fifteen voted moderate,
21 zero voted low and one voted insufficient.

22 DR. MCINERNEY: Thank you. Okay,

1 validity.

2 MR. VENKATESH: So, for validity I
3 think this is -- we've gone into some of
4 this discussion during the importance
5 discussion in terms of the primary concern
6 being that I'm not sure if what we're
7 measuring is what we think we want to be
8 measuring in terms of the preventable
9 dehydration visits within a hospital-based
10 setting.

11 And the reason partly is one of the
12 first things under validity it says is
13 whether the specifications align with the
14 evidence.

15 The evidence is really talking about
16 things that can be done in the ambulatory
17 setting to prevent emergency department
18 visitation or the types of dehydration
19 visits that we now call observation type
20 visits. You know, shorter periods of
21 dehydration. And so I think there's
22 probably not as good of a link there.

1 They tested it at the score level
2 and with a very similar model as before in
3 terms of construct validity that looked I
4 thought fine. The C statistic was just as
5 high as it is for a lot of these claims-
6 based measures. That seemed fine to me.

7 It's adjusted for age and gender.
8 And the exclusions, just to note as a
9 potential threat to validity especially in
10 terms of what you think of in your head, it
11 excludes all patients who are transferred
12 from a skilled nursing facility. And so
13 that may be a population a lot of people
14 think of in their head in this dehydration
15 group that could be preventable and have
16 short hospitalizations. But they're
17 actually out of this measure for similar
18 reasons as to before that Patrick has
19 already kind of highlighted.

20 What that means is I don't think it
21 ends up throwing off the actual validity of
22 the measure that much because two things

1 will happen. One is that it will make -- I
2 mean I think that it just will be -- because
3 they adjust for age while they were also
4 excluding these events at the same time I
5 think an areas estimate will be roughly
6 about even. But remember that those are
7 kind of out.

8 In terms of meaningful differences
9 it's calculated very similar to the other
10 measures. It shows that about 60 to 90
11 percent of counties currently do better than
12 the 80th percentile with 5 to 16 percent
13 that do worse than the 20th percentile. And
14 so that would be potentially the counties
15 with room for some improvement.

16 And then so ultimately I was left
17 with kind of rating this as low. And the
18 reason I rated it as low is that I think
19 that despite all that testing I just am not
20 convinced that measuring inpatient
21 hospitalizations for dehydration is either
22 linked to the evidence or that when you do

1 have that measure that it's meaningful to
2 know what to do with it when we've missed
3 the population that we wanted to measure in
4 the first place.

5 DR. MCINERNEY: Further discussion
6 on validity. Okay, let's vote.

7 MS. ROBINSON-ECTOR: The vote is
8 open. Looks like one vote is missing. All
9 votes are in and voting is now closed. For
10 validity zero voted high, 8 voted moderate,
11 11 voted low and zero voted insufficient.

12 DR. MCINERNEY: Well, that brings us
13 to a screeching halt on this one. The rules
14 are we must have -- must pass both
15 reliability and validity. We passed
16 scientific acceptability and we did not pass
17 validity.

18 MS. MUNTHALI: Yes, so what Adeela
19 is saying, it's in that gray zone. So it's
20 between 40 and 60 percent.

21 So I guess, you know, because of
22 process we want to be consistent with what

1 we did yesterday with the other two measures
2 that were also in the gray zone. I think
3 the co-chairs can ask the committee whether
4 or not they want to proceed and withhold
5 voting. So I'll leave it up to you.

6 DR. SAMPSEL: Well, we can proceed
7 through feasibility. We'll proceed through
8 feasibility and usability as we did and then
9 we could table the final vote.

10 DR. MCINERNEY: Okay. Arjun, would
11 you want to take us through feasibility and
12 usability, please?

13 MR. VENKATESH: Yes. I mean, for
14 feasibility it's the same as the previous
15 measures. It all uses administrative claims
16 data, easily available and the software is
17 available.

18 DR. MCINERNEY: All right. Any
19 discussions on feasibility? Okay, let's
20 vote on feasibility.

21 MS. ROBINSON-ECTOR: Voting is open.
22 All votes are in and voting is closed. For

1 feasibility 15 voted high, 4 voted moderate,
2 zero voted low and zero voted insufficient.

3 DR. MCINERNEY: Thank you.
4 Usability.

5 MR. VENKATESH: Usability. Again,
6 the same thing. It's used in a variety of
7 public health uses, national public
8 reporting uses.

9 The only thing I noted was that one
10 of the things listed on the form was CMS's
11 QRUR reports which are Quality Resource Use
12 -- I don't know what the other R is. But
13 they're given to individual providers --
14 what is it? Resource Use and Quality -- oh,
15 Quality and Resource Use Reports.

16 Anyway, the point is that this
17 measure is again given to people around
18 downstream payment policy and things like
19 that.

20 And so one of my fears was that
21 since one of this includes unintended
22 consequences was that continued endorsement

1 of the measure in some ways signals that,
2 hey, we think that there is some validity to
3 this measure and I'm not so -- you know, I
4 don't really love the idea of saying, hey,
5 we should tell everybody what their
6 dehydration admission rate is when we don't
7 really know if that's what's being measured
8 at all.

9 And then in terms of -- I think that
10 was it. Yes.

11 DR. MCINERNEY: Any further
12 discussion on usability? Okay, let's vote,
13 please.

14 MS. ROBINSON-ECTOR: The vote is
15 open. All votes are in and voting is
16 closed. For usability 3 voted high, 10
17 voted moderate, 6 voted low and zero voted
18 insufficient information.

19 DR. MCINERNEY: Here's the big one,
20 overall suitability for endorsement. We can
21 either delay that vote or we can vote now.
22 What's the pleasure of the committee?

1 Delay? All in favor?

2 MR. STOTO: What will we learn if we
3 delay?

4 MS. KHAN: The purpose of delaying
5 is just so that when we get to public and
6 member comment you can see what the comments
7 are and then decide how you want to vote.

8 DR. MCINERNEY: Okay, so in favor of
9 delaying? Everybody? All right. We will
10 delay that vote.

11 Okay, folks, we are now on the last
12 measure. Congratulations. That's measure
13 0281.

14 MR. FRANCE: Measure 0281 Urinary
15 Tract Infection (PQI 12). Ron and I will be
16 presenting this one.

17 DR. MCINERNEY: Thank you.

18 MR. FRANCE: Or just go ahead and
19 repeat everything Arjun said for the last
20 one almost. They're very similar. ACSC
21 measure rate per 100,000 hospitalizations,
22 in this case for urinary tract infection

1 with similar requirements for numerator as
2 in the last, 18 years and older. Excludes
3 skilled nursing facility transfers, hospital
4 transfers.

5 And has its central view that UTI
6 represents inadequate or delayed treatment
7 for outpatient urinary tract infection.

8 So the first question that we would
9 look to is this question of the evidence
10 base for this outcome measure. And here
11 again looking at our algorithms for outcomes
12 we look directly to the question of whether
13 there's some -- the steering committee views
14 some rationale between outpatient treatments
15 or linkages of health system's failure to
16 hospitalization. Rather than looking at it
17 as a process outcome.

18 Let me just mention a few things
19 around the review. On the evidence side
20 again it's one guideline that they
21 referenced and it was really an outpatient
22 UTI treatment guideline suggesting there

1 aren't clear care pathways about how UTIs
2 should be managed.

3 I think in -- and I might turn to
4 Marcel, but for the elderly it's a little
5 bit less clear about the pathways for
6 diagnosing and treating UTIs.

7 There was also a study that was
8 mentioned from 1998 that showed that for
9 ambulatory care-sensitive condition
10 hospitalizations 10 percent of them were
11 caused by UTIs.

12 Looking at the data for UTIs in
13 general you'll note that there's this
14 variation across age groups. Our working
15 group talked a bit about how the under 65
16 have a relatively low rate compared to the
17 over 65 and that there is this skewedness to
18 the data. And there is variation across
19 regions, ages and genders.

20 So, I'll stop there and see if
21 anybody wants to add anything regarding the
22 evidence question.

1 DR. MCINERNEY: Any discussion,
2 further discussion on evidence? Yes.

3 MS. ASOMUGHA: Just a quick
4 question. So, based on the assessment that
5 you guys did with the evidence. So you're
6 suggesting that there's not clear evidence
7 as to why we need this?

8 MR. FRANCE: So, I think it's this
9 issue that Arjun brought up before that when
10 the outcome -- when you have an outcome
11 measure, then you -- we should be focusing
12 on whether there are processes of care that
13 might be managed.

14 Is there strong evidence that shows
15 that high-quality outpatient care processes
16 leads to these reductions in hospitalization
17 for UTI. There was not a body of evidence
18 presented with this measure along those
19 lines.

20 DR. MCINERNEY: Yes.

21 MR. SALIVE: So, I guess, you know,
22 I'm not sure I fully buy into that theory.

1 I mean, I'm very strongly a proponent of
2 evidence but I think that if I read it right
3 on these ambulatory-sensitive conditions
4 it's an outcome measure and you need a
5 rationale.

6 So the rationale again is that most
7 all UTIs should be able to be managed on an
8 outpatient basis. Maybe not all. Maybe
9 some percentage. I don't know what the
10 percentage is. No one probably around here
11 knows.

12 So, I don't think I buy that that is
13 a lack of evidence that is damning to this
14 kind of measure. It still could be a good
15 measure.

16 So, you know. I'm not sure that
17 that -- it sounds like you're making an
18 analogy rather than that we should not like
19 it. And I don't see that as being very
20 convincing to me.

21 MR. FRANCE: That was not my goal.
22 My goal was to state what was presented in

1 the evidence review which was of a
2 guideline.

3 As a geriatrician I appreciate your
4 expertise in this area and agree that the
5 ideal is of course treating outpatient
6 urinary tract infections leads to reduced
7 hospitalizations.

8 I just would state that that broader
9 question of showing the stronger linkage
10 isn't as clear. And it's not required for
11 the steering committee for us to pass it on
12 evidence.

13 MR. BIALEK: Marcel, I think that
14 the issue maybe gets raised again when we
15 talk about the performance gap. So is there
16 a gap.

17 And within the performance gap there
18 is the issue of can you make a change that
19 will have an impact. Right? That's part of
20 the performance gap discussion.

21 DR. MCINERNEY: Okay. Any further
22 discussion on importance to measure

1 evidence? All right, let's vote on that
2 please.

3 MS. ROBINSON-ECTOR: The vote is
4 open. All votes are in and voting is
5 closed. For evidence 13 voted yes and 7
6 voted no.

7 DR. MCINERNEY: Okay, so that's
8 above our 60 percent by about 5 percent. So
9 I guess we can proceed. How about
10 performance gap, please.

11 MR. FRANCE: So just to point out
12 again that there does seem to be this
13 variation across age groups as well as
14 regions. So there does seem to be a
15 performance gap in hospitalization rates
16 across these different settings.

17 Our group in discussing this
18 wondered whether there may be a future state
19 where this is a performance gap that's
20 focused more on the 65 and older cohort
21 rather than this younger group. See if
22 anybody else wants to add anything to that.

1 That maybe there's a future state
2 where this metric is reviewed by AHRQ and
3 submitted in some future review that is
4 looking more at a segmented 65 and older
5 metric rather than an 18 and older metric.

6 MS. ASOMUGHA: I was just going to
7 ask when can we make that sort of -- that
8 commentary that perhaps this measure would
9 be better if the target age group was more
10 focused on the elderly population where it
11 seems like there's clear evidence that this
12 would be useful. If that's something we
13 could do now or we could do then.

14 DR. MCINERNEY: I don't think we can
15 change it now. It would have to be another
16 submission.

17 Is there someone from the measure
18 development group that would want to speak
19 to this at all?

20 MS. STOCKS: I don't know if Patrick
21 is still on. This is Carol Stocks from
22 AHRQ. We could certainly take that into

1 consideration. I think we'd want to do some
2 testing first to see the impact.

3 DR. SAMPSEL: I would say this is
4 one of those we'll capture in the meeting
5 notes. The information will be given back
6 to the developer. And they are listening
7 and taking notes anyway. And it's something
8 they can consider for the future. But we
9 need to consider this measure as it is.

10 DR. MCINERNEY: Ron.

11 MR. BIALEK: Back to Eric's comment
12 initially. When we look at the performance
13 gap it's a demonstration of quality problems
14 and opportunity for improvement.

15 The data that were provided by the
16 measure developers was that there's an
17 opportunity to reduce hospital admissions
18 potentially by 10 percent. And the
19 developers say that 10 percent is by having
20 access to ambulatory care. And there was
21 one study that related to that.

22 So, a couple of issues. One is the

1 opportunity is present but the percentage is
2 relatively low. The developer really didn't
3 offer a lot on how to impact that. And the
4 access issue if they meant use of ambulatory
5 care is a little bit different than access
6 too because the population may have access
7 but not the ability to use. And so I just
8 wanted to raise those as far as the
9 performance gap goes.

10 DR. MCINERNEY: Thank you. Any
11 further discussion on the performance gap?
12 Okay, let's vote on that. I'm sorry.
13 Marcel.

14 MR. SALIVE: So I think one other
15 gap is that it's going up. So I do think
16 there is -- I mean, there's a temporal trend
17 going up which suggests -- it may be more
18 than 10 percent if you buy into the 10
19 percent potential improvement. And that's
20 still a considerable amount of morbidity,
21 that 10 percent. It's a very high rate.

22 DR. MCINERNEY: Okay, let's vote on

1 performance gap, please.

2 MS. ROBINSON-ECTOR: The vote is
3 open. All votes are in and voting is now
4 closed. For performance gap 4 voted high,
5 14 voted moderate, 2 voted low and zero
6 voted insufficient.

7 DR. MCINERNEY: Okay. The next to
8 vote on is priority. Who would -- you want
9 to continue the discussion on priority,
10 please?

11 MR. FRANCE: Here I am drawing a
12 blank. I'm trying to think what's the best
13 way to say it.

14 I think there was the sense that UTI
15 hospitalization in that ideal framework is
16 prevented with the high-quality outpatient
17 patient care delivery system may face some
18 of the same threats as -- this might be more
19 about construct validity to a degree. Sort
20 of what Arjun was saying with the whole
21 dehydration issue.

22 As was mentioned there's this

1 increasing rate. There wasn't a real clear
2 understanding about why those rates were
3 going high. They said maybe it's because of
4 increased emergency department use as an
5 outpatient setting.

6 But there wasn't much data that they
7 shared with us. They talked maybe obesity
8 and diabetes incidence increases might
9 explain it. It could be due to higher rates
10 of resistance to antimicrobial therapy as
11 another source of this increasing rate.

12 So is UTI hospitalization a high,
13 moderate, or low priority for the nation and
14 health and well being? I don't know that we
15 came up with a strong answer. Again, maybe
16 I'll ask others to comment in. Ron?

17 DR. MCINERNEY: Further discussion
18 on priority? Okay, let's vote, please.

19 MS. ROBINSON-ECTOR: The vote is
20 open. All votes are in and the voting is
21 now closed. For high priority 3 voted high,
22 12 voted moderate, 5 voted low and zero

1 voted insufficient.

2 MR. FRANCE: All right, so from a
3 reliability perspective they did a report on
4 a variety of statistics. The ratios seem to
5 suggest that it is a reliable, moderately
6 reliable metric as it's constructed.

7 From a validity perspective while
8 there may be these broader questions of
9 construct validity they did do the modeling
10 that we talked about this morning that
11 seemed to align UTI inpatient
12 hospitalization with characteristics of
13 communities that are aligned with the
14 infrastructure of the healthcare system.

15 So reliability seemed moderate.
16 Validity seemed high as a specific measure
17 but from a -- and moderate from a construct
18 validity perspective.

19 DR. MCINERNEY: Any further
20 discussion on the reliability? Okay, let's
21 vote, please.

22 MS. ROBINSON-ECTOR: Voting is open.

1 All votes are in and voting is now closed.
2 For reliability 7 voted high, 12 voted
3 moderate, 1 voted low and zero voted
4 insufficient.

5 DR. MCINERNEY: Thank you.
6 Feasibility. I'm sorry, validity. I'm
7 ahead of myself. Validity, sorry.

8 I guess we're all ready to vote on
9 validity. Please.

10 MS. ROBINSON-ECTOR: The vote is
11 open. All votes are in and the voting is
12 now closed. For validity 4 voted high, 14
13 voted moderate, 2 voted low and zero voted
14 insufficient.

15 DR. MCINERNEY: Okay, now we can go
16 to feasibility.

17 MR. FRANCE: Yes, so here the
18 workgroup all agreed that it's like other
19 metrics generated by electronic sources in
20 claims. So we consider it feasible. It's
21 feasible.

22 DR. MCINERNEY: Further discussion

1 on feasibility? All right. Vote, please.

2 MS. ROBINSON-ECTOR: Voting is open.
3 One vote is missing. All votes are in and
4 voting is now closed. For feasibility 16
5 voted high, 4 voted low -- moderate, sorry.
6 Moderate.

7 DR. MCINERNEY: Usability.

8 MR. FRANCE: Again as a group we
9 thought that this was a measure that was
10 being used and that it is usable.

11 It may run into the same questions
12 around whether it's a reflection of the
13 classic UTI hospitalization issue, or if
14 these are a more complex complicated group
15 of patients in the hospital now than they
16 were when this metric was originally
17 created.

18 In general though it is being used
19 across counties and states.

20 DR. MCINERNEY: Further discussion
21 on usability? All right, let's vote,
22 please.

1 MS. ROBINSON-ECTOR: Voting is open.
 2 All votes are in and voting is now closed.
 3 For usability 8 voted high, 11 voted
 4 moderate, 1 voted low and zero voted
 5 insufficient information.

6 DR. MCINERNEY: All right. Here we
 7 are at the finish line. We now have the
 8 overall suitability for endorsement for this
 9 measure. Any further discussion on this?
 10 Okay, let's vote, please.

11 MS. ROBINSON-ECTOR: Voting is now
 12 open. All votes are in and voting is now
 13 closed. For overall suitability 15 voted
 14 yes and 5 voted no. For measure 0281
 15 Urinary Tract Infection Admissions Rate (PQI
 16 12) the measure passes.

17 DR. MCINERNEY: Well, great. Thank
 18 you, everyone. We made it through all of
 19 our measures. And now the reward is a nice
 20 one and a half hour presentation about
 21 harmonization.

22 (Laughter)

1 DR. MCINERNEY: I know. We need to
2 do comments first and then we can do our one
3 and a half hour presentation on
4 harmonization. So can the operator let us
5 know if there are any comments?

6 OPERATOR: To make a comment please
7 press * then the number 1. And there are no
8 public comments at this time.

9 DR. SAMPSEL: So, I'd just like to
10 thank Patrick and Carol from AHRQ for
11 joining us and answering the questions that
12 we had. And Patrick for joining us so early
13 from the west coast.

14 MR. ROMANO: Thank you very much.
15 I'm back. It's been a pleasure to be part
16 of the committee discussion. If there are
17 other comments or suggestions of course
18 we'll be happy to share those with the AHRQ
19 team.

20 MS. STOCKS: Okay, thank you.

21 DR. MCINERNEY: Very good. So, NQF
22 team, what are we doing now?

1 MS. MUNTHALI: Actually, Adeela is
2 going to give the committee a background on
3 harmonization. And I'll talk a little bit
4 about gaps. But it will not be an hour and
5 30 minutes. We'll try and get you out
6 before 3.

7 DR. MCINERNEY: Thank you.

8 MS. KHAN: Okay, thank you, everyone
9 for your hard work. Now you'll just have to
10 listen to me speak for another 15 minutes.

11 So I'm here to talk about
12 harmonization and harmonization within the
13 NQF portfolio.

14 Just a little bit of background.
15 The quality landscape contains a
16 proliferation of measures and some that can
17 be duplicative and overlapping. They
18 address the same conceptual measure focus
19 and the same target population.

20 So this creates a lot of confusion
21 in the field for people to interpret these
22 performance results. And it also can

1 increase the data collection burden for
2 providers.

3 So our goal is to standardize and
4 align specifications and definitions for
5 related measures that can help alleviate
6 some of these problems. And when there is a
7 sufficient amount of overlap we like to
8 select a best-in-class measure to be the
9 most appropriate measure for us to use.

10 So we actually wanted to go over
11 this because we do have several related and
12 competing measures in this project.

13 Just talking quickly about
14 definitions. When we're talking about the
15 measure focus we're looking at the target
16 process, the condition, the event and the
17 outcome. And for the patient population
18 we're looking at the regular patient
19 population, who was being measured.

20 So here's a table here that can --
21 it's an algorithm basically for telling you
22 whether or not the measure is related or

1 competing.

2 Some of the principles for selecting
3 the best among competing measures is
4 multiple competing measures can be --

5 MR. SPANGLER: Adeela? I'm sorry,
6 can you get closer to the mike?

7 MS. KHAN: Oh, sure.

8 MR. SPANGLER: Thanks.

9 MS. KHAN: So multiple measures can
10 be accepted with adequate justification.
11 NQF prefers the endorsement of measures that
12 include the broadest possible target
13 population for whom the measure is
14 appropriate and indicated by the evidence.

15 NQF prefers endorsement of measures
16 that assess performance for the broadest
17 possible applications. So, for as many
18 possible individuals, entities, settings and
19 level of analysis for which the measure is
20 also appropriate.

21 Just to continue, if a single
22 measure cannot accommodate the inclusion of

1 all relevant patient populations or entities
2 a second measure can be considered for
3 endorsement in which case we would ask that
4 the measures be harmonized to the extent
5 possible.

6 When the best-in-class measure is
7 not clear it's appropriate to endorse more
8 than one competing measure. At the time of
9 initial NQF endorsement NQF should identify
10 analyses needed to conduct vigorous
11 evaluation of the use and usefulness of the
12 measure.

13 This information should be provided
14 by the developers to support a best-in-class
15 determination at the time of our three-year
16 maintenance.

17 Until the clinical data from EHRs
18 are widely available for performance
19 measurement and reporting, endorsement of
20 competing measures based on different data
21 types can be justified.

22 Two measures may be needed to

1 achieve the dual goals of, one, advocating
2 widespread access to performance results,
3 and two, mitigating to performance measures
4 based on clinical data on EHRs.

5 Some of the principles for measure
6 harmonization. Harmonization should not
7 stifle innovation and it should be ideally
8 addressed before the measures are submitted
9 to NQF. And all of the measures that we
10 have in this project actually were -- the
11 developers were told beforehand if they had
12 a competing or related measure and they all
13 did speak to each other.

14 The reason they weren't evaluated in
15 this project was because they're out of
16 phase. Some of the measures that are in the
17 health and well being portfolio are not
18 being evaluated during this phase of the
19 project. So when they do come up again
20 together that's when we'll tackle the
21 harmonization issues. Which is why we
22 wanted to just give you a primer as to why

1 that's important anyway.

2 Harmonization should not result in
3 inferior measures. Measures should be based
4 on the best measure concept and the best way
5 to measure those concepts.

6 And then conceptual harmonization,
7 whether the measures are intended to address
8 the same focus and target population should
9 be determined before harmonization of
10 technical measure specifications. So, your
11 definitions, codes and algorithms.

12 Harmonization should eliminate
13 unintended differences among the related
14 measures. When there's a decision not to
15 harmonize the measures the value of the
16 different conceptualizations and technical
17 specifications should outweigh the burden
18 imposed.

19 And the availability of standardized
20 definitions and specifications that can be
21 used across measure is a desired goal, but
22 they often cannot be established a priori.

1 So measure harmonization efforts will
2 facilitate achieving standard definitions
3 and specifications.

4 So here's a list of the related and
5 competing measures within the health and
6 well being portfolio. The diabetes measure,
7 diabetes long-term complication admission
8 rate is related to 0272 Diabetes Short-term
9 Complication Rate and 0638 Uncontrolled
10 Diabetes Admission Rate.

11 2511 Utilization of Dental Services
12 is also related to 1334 Children who Receive
13 Preventive Dental Care which was developed
14 by HRSA, and 1388 Annual Dental Visit
15 developed by the NCQA.

16 We also have one competing measure
17 in this project, 2528 Prevention Topical
18 Fluoride for Children at Elevated Caries
19 Risk. And that we found was competing with
20 1419 Primary Caries Prevention Intervention
21 as Part of Well or Ill Childcare as Offered
22 by Primary Medical Providers.

1 MR. KROL: I think I'm struggling
2 with what determines competing. So, for
3 that measure if I remember correctly the
4 provider being measured in one is the
5 dentist and on the other it's non-dentists.
6 So, is it just the competition that they're
7 providing a potentially similar service or
8 partially similar service? I'm sorry.

9 MS. MUNTHALI: Yes, I don't know if
10 we have the comparison table up. I think
11 that would be helpful. Because what we do
12 is spec it out against the data elements,
13 the setting of care. So it's a side-by-side
14 comparison. And I'm sorry, I don't have it
15 in front of me.

16 But for one reason or another we
17 made the determination that it did fit
18 within the competing measures category
19 because the -- it had the same concept for
20 our measure focus and target process and in
21 the same target population.

22 So I would be better able to -- I

1 don't know if you have the comparison. If
2 you can bring it up we could show you where.

3 MR. KROL: That's okay. Just, I
4 know they made an important point, at least
5 I thought it was an important point of
6 delineating dental services from oral health
7 services. And the competition would lie in
8 the oral health services side of things
9 rather than the dental services side with
10 those two.

11 MS. NISHIMI: Right, and then the --
12 the exception would then be because there
13 might be a need for both of them that's why
14 the committee would choose to apply that.
15 But on its face for the other details they
16 would be considered.

17 MS. MUNTHALI: And some of their
18 explanation came about as a part of this
19 process and not in their submission form.

20 So when we're initially determining
21 whether or not measures are competing or
22 relating, we are looking at their submission

1 form and then we get additional information,
2 clarity from developers on what exactly they
3 mean.

4 MR. BIALEK: And so the
5 harmonization issue does not go beyond NQF?
6 So Health People 2020 is off the table. Is
7 that true?

8 MS. MUNTHALI: Yes. So our
9 harmonization protocol and process is based
10 on our endorsed measures. So a measure must
11 be endorsed before we consider it -- NQF-
12 endorsed before we consider it for
13 harmonization.

14 But we could recommend to I think it
15 was AHRQ when we were talking about Health
16 People 2020. And we could recommend that
17 they make, you know, they do align their
18 measure with the denominator. And I can't
19 remember the specifics of the conversation,
20 but yes.

21 MS. BURSTIN: But just to add to
22 that, I think that's a really good point,

1 Ron. And I think if you know from where you
2 sit that there are in fact other standards
3 out there that may not be part of our
4 process, but others will be held to for
5 other reasons that would be really
6 informative I think to just bring it to us
7 for information's sake.

8 Because the last thing you want to
9 do is have people be forced to -- the whole
10 point of this is to reduce burden and make
11 sure people are being measured on what the
12 quality signal really is and not just undue
13 burden.

14 MR. BIALEK: And there are a couple
15 of in the oral health area around sealants
16 and use of dental services.

17 MR. STOTO: Are we being asked to do
18 something at the moment about this?

19 (Laughter)

20 MS. KHAN: No, this is just a primer
21 for the committee. Just because we never
22 really get a chance to really delve into

1 what we mean when we say measure
2 harmonization.

3 And so as part of a new
4 organization-wide change we want to really
5 up front bring the conversation about
6 harmonization to the committee just so that
7 when the time comes you're ready for the
8 discussion.

9 MS. MUNTHALI: And it is a change.
10 Sorry, Mike you were on previous projects.
11 So what we did on previous projects was to
12 start talking about harmonization and an
13 action was required at the in-person
14 meeting.

15 But we realized developers didn't
16 have an opportunity to prepare their
17 discussion points around harmonization,
18 whether or not it's justified or not.

19 And then also as Adeela said some of
20 the measures were not due for their
21 maintenance review. So we were asking of
22 them additional information before time.

1 And we realized that what we'd like
2 to do now is kind of point out where we see
3 some concerns over harmonization or where
4 there may be competing or related measures,
5 and then give them time to work that out.
6 They've had those initial discussions as
7 Adeela has said. And so we'll see where
8 they go from here.

9 MR. STOTO: So, the ones that are
10 already endorsed, they're endorsed. So the
11 question is about the new ones, whether they
12 can be more harmonized with that.

13 MS. MUNTHALI: All of them are
14 endorsed.

15 MR. STOTO: I mean are you -- will
16 you ask the people who have had a measure
17 endorsed last year or the year before to
18 reconsider it?

19 MS. BURSTIN: Yes. And that's the
20 point of this is we will bring the portfolio
21 to you. We'll have an opportunity. And
22 they have then a year till their annual

1 update to harmonize, make sense of this.

2 We know they can't get it done
3 immediately. Their processes don't work
4 that way. We want to give them your best
5 thinking.

6 And so a measure that's out there
7 that's been endorsed for a year is just as
8 much up for harmonization as one that's
9 newly brought forward to you.

10 We just want to get the best-in-
11 class out there, reduce duplicate measures
12 that are slightly off. There's nothing
13 worse than that as a clinician I think for
14 many and others.

15 MS. MUNTHALI: And the measures in
16 this project, of course we wouldn't be able
17 -- it wouldn't be confirmed until they were
18 endorsed. And you just endorsed them and so
19 this is why we're bringing them to you.
20 You've just recommended them for endorsement
21 I should say.

22 MS. KHAN: Are there any other

1 questions? Eric?

2 MR. FRANCE: I'm sorry, just to
3 remind myself, the competing. Weren't those
4 two different bodies of care delivery
5 systems, the first being dentists and the
6 second being pediatricians and family
7 physicians? And so are they competing in
8 that regard or are they related?

9 MS. KHAN: They were classified as
10 competing because they have the same measure
11 focus and the same target population. The
12 treating physician wasn't really taken into
13 consideration.

14 MR. FRANCE: Thank you.

15 MS. KHAN: Okay, I can turn it over
16 to Elisa to talk about gaps.

17 MS. MUNTHALI: Thank you, Adeela.
18 This will be a very quick discussion just
19 because of time. But also we would need
20 quite a bit of time to talk about this.

21 But before we did start talking
22 about the gap areas in our previous project

1 we talked about some of the concerns around
2 trying to get the measures that the
3 committee would like to see and NQF would
4 like to see come through our process.

5 And for us at NQF we think that this
6 is probably more important to tackle. We've
7 been all through the MAP process, the
8 measures applications process and our most
9 recent project on the Community Action Guide
10 and also this project. We've been talking
11 about the gap areas.

12 And we did put a chart after this
13 that kind of maps out the different areas
14 that each group has mentioned. But we're
15 really struggling about how we can get those
16 sort of measures here, how we can connect
17 with communities that may be using measures
18 and see if they can come through the
19 process.

20 These were some of the strategic
21 recommendations that the prior committee
22 came up with some of which we're already

1 tackling because they're global concerns
2 that we have across multiple projects, not
3 just the population health, health and well
4 being project.

5 But I just wanted to share these
6 with you. And we will probably follow up
7 online or through our conference call to
8 talk about gaps further. But I'll just go
9 down the list.

10 One of the concerns or one of the
11 ways that our committee, our previous
12 committee said we could probably improve
13 future calls for population health and
14 health and well being measures is to
15 identify population health measures that
16 potential partners may be using.

17 So, to conduct a collaborative
18 analysis of those partners which is
19 essentially environmental scan.

20 We think that through the work that
21 we're doing now through the Community Action
22 Guide it's very different for NQF to be in

1 this space because we will be going out to
2 communities, working with communities in
3 addition to public health sectors and the
4 clinical care delivery system to see what we
5 can do to help improve population health.
6 So that might be one way that we're doing
7 it. But we'd welcome your ideas and
8 suggestions on how we can move forward in
9 this respect.

10 Another was really trying to refine
11 guidance and definitions that we provide
12 developers and our committees. Many have
13 criticized us because they have said that
14 the definitions and guidance that we've used
15 have been very clinically focused. And so
16 we may be talking the same talk as people in
17 the communities but no one knows that
18 because it's very medical-focused. And so
19 they suggested that we come up with examples
20 and guidance of what good looks like.

21 We are really happy to announce that
22 since this project in 2011 we've done that

1 for all developers. It's part of the
2 developer guidebook. You received a
3 steering committee guidebook but we
4 developed also a developer guidebook that
5 includes examples of what good looks like.
6 And so we'd like to move further here as
7 well to see perhaps there are other examples
8 for folks that are working on community
9 health measures or population health
10 measures.

11 Another criticism is that our
12 submission process can be very odious and
13 very burdensome. And so they had suggested
14 to our committee that we provide more
15 detailed technical assistance.

16 And this is something that we've
17 done throughout all of our projects. We've
18 added technical assistance as actually a
19 budgetary line item in all of our project
20 budgets.

21 And we worked very closely, for
22 example, with the Dental Quality Alliance.

1 We worked with them for several months for
2 them to prepare their submissions for this
3 project.

4 They also suggested establishing an
5 interactive community forum where there can
6 be some sort of bidirectional learning and
7 sharing. And this is something we're
8 continuing to work through, talk about how
9 we can do this.

10 But one of the things we do have,
11 we've had for many years is monthly
12 developer webinars. And so population
13 health is one of the topic areas that we're
14 talking about, not just that we have this
15 work at NQF but also talking about some of
16 the methodological challenges to population
17 health measure development.

18 And many thought that NQF really
19 needs to confirm what their value
20 proposition is to folks who are working in
21 communities, people working on population
22 health. We are working towards that.

1 As Helen has mentioned it is a very
2 large strategic goal of ours to improve and
3 strengthen population health work. And
4 we're doing it through the different
5 projects that we've all mentioned over the
6 last couple of days.

7 And so I don't know if you have any
8 other suggestions of what your general
9 feedback is on some of these strategic goals
10 that were set about two years ago. Many on
11 this committee were on that committee. And
12 so I don't know if you would like to share
13 your perspectives.

14 MR. STOTO: I was and I think these
15 were important. I especially think the last
16 one is important. Because I think that as
17 much as people have come to realize the
18 value of endorsement by NQF in the
19 healthcare sector people in the public
20 health sector have no idea even what it is.
21 And so.

22 And I think that one way that we can

1 address that is in the area of community
2 health needs assessments, that hospitals are
3 now required -- that non-profit hospitals
4 are all required to do. And the health
5 departments are required to be part of that,
6 although that doesn't always happen as well
7 as we'd like.

8 And you know, if in the IRS guidance
9 that says what is an acceptable community
10 health needs assessment is something about
11 NQF endorsement being important that would
12 make a tremendous amount of difference.
13 Right now the IRS guidance says almost
14 nothing about what makes an appropriate
15 measure. It says nothing about what makes
16 an appropriate measure for a community
17 health needs assessment.

18 DR. MCINERNEY: The United States
19 clearly lags behind most of our European
20 countries as far as public health and
21 healthcare quality and quality of health of
22 our citizens compared to countries in

1 Europe.

2 And I just wondered are there some
3 things that are going on across the pond as
4 they say that we may be able to learn from
5 what's happening in those countries that can
6 help us inform how to improve our quality,
7 one of the three measures there, the
8 healthcare quality of our population as a
9 whole? I wonder if folks have thought about
10 that.

11 MS. BURSTIN: Yes, so we've actually
12 got some projects where we've actually been
13 trying to get some of the learnings from the
14 other countries across the pond.

15 And in fact have a project right now
16 we're doing on gaps on patient-reported
17 outcomes which has been directly, for
18 example, looking at the PROs already in use
19 in the UK.

20 So again, as we think about this
21 going forward examples of international
22 measures that we should consider bringing

1 forward in the U.S. would be very welcome as
2 well.

3 I mean, we often hear about how some
4 countries like Sweden have 10 measures they
5 use to manage their health. That would be
6 glorious in comparison to the hundreds that
7 we have in Health People 2020.

8 And then also just another thing to
9 keep an eye on is the fact that the IOM has
10 a committee right now on coming up with a
11 core set of measures.

12 And at least from those I know on
13 the committee, not who can share
14 significantly, imply it's again at a fairly
15 high level. I think it will be more at the
16 population level as well.

17 So, I think there's a lot of things
18 happening -- that's coming out in August --
19 that we should keep an eye on.

20 MR. BIALEK: Just a couple of
21 thoughts. This is highly conceptual for
22 many of us in public health. And if there

1 are any examples of users who are not
2 clinical providers that would be enormously
3 helpful as well as examples of the actual
4 measures of what's released from NQF. So
5 that would enable us to take that to other
6 organizations who may be willing to develop
7 measures.

8 A second item has to do with the
9 time frame which tends to be fairly short.
10 And even, you know, we heard from our
11 colleagues from AHRQ who did a magnificent
12 job how difficult it was to put all of that
13 together in the time frame.

14 And I think when we're reaching out
15 to non-governmental organizations or
16 organizations that are not quite as large as
17 we may be accustomed to, the time frame
18 maybe needs to be extended.

19 MS. BURSTIN: And part of our goal
20 as well in our discussions with CMS about
21 our contract going forward will be not to
22 have sort of this rush of deadlines for

1 these various projects, but instead to have
2 a more smoothed out process. So we're
3 piloting that currently in our endocrine
4 project where measures can be submitted
5 every six months to the standing committee.

6 Whether that will be every six
7 months or annually it would allow people to
8 say it's not this urgency, oh my God, if I
9 don't get it in now I can't get it in for
10 two or three years. So I think that's our
11 vision for that, Ron, and I think that would
12 help.

13 MS. NISHIMI: And, Ron, I'm going to
14 correct the record here because I'm a
15 consultant and I can do it on behalf of NQF.

16 But AHRQ was actually given a pass
17 two years ago and they've known for a year
18 and a half that they had to meet these
19 deadlines. So, the comment by the developer
20 that they had 48 hours was entirely the
21 developer's doing.

22 MR. VENKATESH: I guess I have two

1 sets of comments.

2 One is conceptually I think we
3 sometimes miss the title of the committee
4 which is Health and Well Being. And the
5 vast majority of measures we evaluate -- and
6 that's reflected in the vast majority of the
7 measures we have are really of sickness and
8 not well being, right? And that is largely
9 a construct of data that we have available
10 too.

11 But it would be nice if in the
12 future the way the strategy is set up is in
13 a way where it thinks about what actual well
14 being measures, like what type of functional
15 status measures might there be for high-risk
16 populations and things like that where
17 you're actually health-promoting measures as
18 opposed to the avoidance of bad events.

19 And along those lines I think that
20 the challenges that the data right now that
21 we've traditionally used is a lot of
22 administrative claims or even things that

1 we're going to pull from electronic medical
2 records are still going to capture bad
3 things.

4 And so in that vein at least I came
5 up with three ideas of things I think would
6 be good community-level measures and address
7 -- one thing we hadn't done is we didn't
8 really look at what we have here across the
9 National Quality Strategy by domain.

10 And two domains that stuck out to me
11 as missing where the community level
12 actually may be hopefully a less politically
13 charged place to measure and may actually be
14 a better place to measure around care
15 coordination and affordability.

16 And so for care coordination, a
17 couple of measures that came to mind is why
18 are we not measuring community-level risk
19 standardized readmission rates.

20 The argument from the hospitals has
21 been this is largely driven by a lot of
22 community resources and factors. And we

1 have a lot of other things, some research
2 that says communities may drive that.

3 I'm biased because we make these
4 measures. But I think that's one type of
5 measure.

6 Another would be we haven't really
7 gotten into the behavioral health space a
8 lot with a lot of measures within this
9 group. And so I was thinking about
10 something that would measure days in
11 emergency departments or observation stays
12 prior to a psychiatric hospitalization as a
13 measure of mental health care access in a
14 community.

15 And then the last one I thought
16 about was something that we're trying to
17 deal with in New Haven is that on the
18 affordability side for communities we really
19 think about that in the municipal level.
20 And healthcare costs are bankrupting our
21 community. And that's really spending on
22 public employees' healthcare benefits.

1 And so we have measures of total
2 spending per beneficiary. What if we
3 applied that to all public employees within
4 a community? And thought about how much we
5 were spending of community dollars within
6 the community on healthcare.

7 And so I think there's ways to start
8 going -- those are all kind of controversial
9 ones. But I think that we should be
10 thinking about each of those domains as well
11 as also health measures.

12 MR. CARILLO: Yes, in the past two
13 days perhaps a leading recurring theme is
14 the social determinants of health. And I
15 think that they apply not just to the
16 population health space but they apply
17 across the board and practically with any
18 health measure you can think of. So I
19 wonder to what extent that's something that
20 NQF can focus on.

21 I think, for example, our PQI
22 measures that we went over today, if we had

1 parallel measures of social determinants you
2 might be able to get a better sense of what
3 the measure is telling us.

4 I mean, we were uncomfortable with
5 several of the PQI measures because of that,
6 because of all the confounding. And
7 frankly, I mean the committee was almost
8 uniformly and unanimously concerned on those
9 bases. So I think that that's an important
10 priority that I would recommend.

11 MR. STOTO: Coming back to the
12 question of international comparisons. A
13 number of European countries have something
14 called population health observatories. And
15 I don't know much about them but there's a
16 network of them. And it might be
17 interesting to see what kind of measures
18 that they are using in their work.

19 MR. SPANGLER: I wanted to go back
20 to Arjun's point. Because this came up when
21 we were on the previous committee about
22 population health. Can we get health

1 measures.

2 And one of the things that we kept
3 hearing from the developers is we can't do
4 it. They're too difficult to develop. They
5 cost too much money. They're too expensive.
6 It can't meet the criteria that NQF has.

7 And I know you guys have tried to
8 change the criteria a little bit to adapt to
9 that, but I still think that's an issue with
10 measure developers.

11 And also, historically most measure
12 developers, they don't know how to develop
13 these type of measures. So we need other
14 people to kind of come in and help them do
15 that.

16 And I know that that's a process
17 that's going to take awhile. But I think
18 some of those issues that we had discussed
19 previously are still there.

20 MR. STOTO: You know, the Behavioral
21 Risk Factor Surveillance System has data on
22 healthy days that's used quite widely. And,

1 you know, we used other BRFSS data all the
2 time in this kind of stuff.

3 And you know, if our standards are
4 such that that doesn't pass then maybe we
5 should think about changing the standards.

6 That's out there, it's being used
7 all the time. The county health rankings do
8 it for every county in the country every
9 year.

10 MS. BURSTIN: And just one more
11 comment to add into that. One of the things
12 we've also been talking a lot about is
13 whether we've moved beyond the days of a
14 binary yes/no for NQF endorsement, and
15 whether endorsement should be more related
16 to fit for purpose.

17 So if a measure is intended, for
18 example, for population surveillance, or QI
19 versus payment, would you have different
20 requirements even among testing. I mean,
21 what kind of testing do you need if you're
22 measuring a community who may not have a

1 pay-for-performance attached to it or public
2 reporting?

3 It gets complicated. In the past
4 when NQF has done this years ago, before I
5 came, in one particular project around
6 cancer. The concern we heard from a lot of
7 the consumers and purchasers was that some
8 of the measures they cared about most wound
9 up in the QI-only surveillance realm. So we
10 have to be really careful of what that looks
11 like.

12 But I think it really goes all the
13 way back to measure development. Sometimes
14 there are measures that just will be
15 developed differently if your intended
16 purpose is not for some of the sort of high-
17 stakes financial accountability where
18 misclassification has a pretty significant
19 effect.

20 But also public reporting. I mean,
21 the last thing you also want to do is have
22 somebody go to a website and find

1 information that's incorrect because the
2 measure is not sufficiently valid.

3 MR. SALIVE: I also agree about
4 measuring health and think that we should
5 try to do it. And I agree that functional
6 status is a good idea there, quality of
7 life.

8 And on the flip side I think I have
9 some thoughts about the older population and
10 multi-morbidity is another thing which I
11 think has been ignored both by the health
12 system and by population health.

13 And we touched on this today I think
14 with the exclusion of nursing home patients
15 from a lot of these measures, saying that
16 they're measures of the community. And I
17 think that it disenfranchises the nursing
18 home people really by doing that, that they
19 have these issues. And they're in the
20 healthcare system, kind of, and they're
21 definitely living in the certainly.

22 It's a fine public health transition

1 that they've excluded them from the
2 denominator. And so then you argue well,
3 they can't be in the numerator either.

4 But I think that begs the question
5 of why and we need to fix that I think
6 sometime down the line.

7 I also had one final technical
8 comment which is just that bullet that said
9 something about the value proposition to me
10 is very cryptic.

11 And so I think that whenever you
12 talk about value, I know it's a loaded term,
13 so value to who. And who is spending the
14 money on that.

15 Is it really just that your measures
16 will be used, is that what this is about?
17 Because I would be in favor of that.

18 Or is it about that we should have
19 measures that deal with economics?

20 So I guess I would just -- I think
21 those are good ideas, that we should flesh
22 this out a bit and not leave it in this sort

1 of crypto-speak. You know, we don't want to
2 say we're going to save money or have death
3 panels, I'm sure.

4 MS. MUNTALI: No, I think this was
5 really focused on engagement with people
6 that have typically not engaged with NQF.
7 So, people outside of the clinical care
8 delivery system. And really, what is the
9 value of them coming through our endorsement
10 process.

11 And I will actually share with you
12 the final report. I think the committee did
13 a fabulous job and their recommendations
14 were spot on. I think it will provide
15 additional context.

16 MS. FRAZIER: As I said earlier or
17 yesterday, one of the reasons, probably the
18 only reason that I did this committee is
19 because I really want to help with the
20 transition out of the medical mode in how we
21 look at health and well being.

22 And I think that a couple of things

1 I've heard that make me feel that we can
2 move that transition. It's going to take
3 time.

4 One is an openness of NQF to re-look
5 at their measurement process. To be open to
6 new ways of looking at measures and how we
7 effectively do that.

8 I think two is the research, all the
9 best practices we can all over the country.
10 Because I think there are people doing
11 things that we're not even thinking about
12 when it comes to health and wellness.

13 I'm reading material that is
14 fascinating and innovative but it doesn't
15 fall into the box that we're used to. So I
16 have to open up my mind as well of how to do
17 this.

18 I think third is to take advantage
19 of tools that we already have. When I look
20 at the behavior risk factor I don't love it,
21 but I think was it applied more in local
22 communities it may be more effective.

1 The way it's used now is so broadly
2 -- the way the CDC uses it is just not as
3 effective. It's difficult to utilize it in
4 a way to be actionable. So I think it is a
5 tool, I agree with you, but I think it has
6 to be reapplied differently.

7 So I mean those are the three
8 thoughts I have. But I think this is going
9 to take some transition.

10 And I think one of the things that
11 this committee can do is maybe getting some
12 things to read to try to begin opening up
13 our minds to figure out how we do this
14 differently. So that would be my thoughts.

15 DR. SAMPSEL: And I would just
16 follow up on that. And I can help try to
17 pull some things together.

18 But I was recently working on a
19 project with a hospice expert. And it was
20 talking about measure development in
21 hospice.

22 And she had some comments about

1 measuring patient priorities. And I said
2 well how do you do that, what's the
3 evidence? She said well quit thinking like
4 a measure developer and you'll figure it
5 out.

6 And you know, I haven't been a
7 measure developer for five years now but
8 it's still hard for me to think outside of
9 the evidence, you know, testing and all of
10 those features.

11 So I agree, it's stepping outside of
12 the box, learning best practices, because
13 there are some opportunities out there. And
14 I think one such thing is PROMIS. Just
15 really kind of an opportunity to think
16 differently.

17 And the other area I think of great
18 need, it's hard to figure out where it fits
19 though, is that quality of life that I think
20 I've heard a couple of folks mention, that
21 everybody is struggling with.

22 How do you measure quality of life

1 and what does quality of life mean based on
2 where you are on an epidemiological scale?

3 MS. MCKANE: I just wanted to add
4 that I've been kind of the survivor of a
5 number of different indicator projects that
6 are ongoing as that's a very popular thing.
7 We're epidemiologists and we're in public
8 health so we have to measure everything.

9 And I think that there is a place
10 for NQF and population medicine to work
11 together on this. Because when I see these
12 indicators, the quality varies, the criteria
13 varies. There's really, there's a lack of
14 consistency. And it would be really nice to
15 have a consistent source that you could
16 refer to.

17 And actually we often are, you know,
18 we go through the NQF indicators. We go
19 through the other ones that are online that
20 have been through a vetting process and
21 we're trying to look at things. So I think
22 that there's certainly -- I think there's a

1 value in that. And I would like to see it
2 proceed. I do think some of the hurdles
3 that everybody has described we need to work
4 on.

5 And the other thing I have to point
6 out because I am an epi and we do work with
7 BRFSS data is that we don't really
8 particularly care for the county health
9 rankings and the methodology. It's not
10 really been approved by CDC. We kind of --
11 we take the data and do the modeling.

12 But -- and CDC is working on
13 developing methodology to improve -- to
14 develop a consistent method of developing
15 county-level data. We actually do it in
16 Michigan at county level.

17 It depends on the population because
18 smaller areas, smaller counties may need
19 more years of data. And it does affect the
20 validity.

21 MR. FRANCE: Last word. Just to
22 remind us that health occurs more in the

1 communities than in our clinics, that it's
2 where we live, work, learn, play, pray. And
3 so those are all domains that we might want
4 to think about, work site, school site,
5 family health.

6 And not be afraid of the fact that
7 that feels kind of weird to think that way.
8 But that's where health and well being
9 lives.

10 MS. MUNTHALI: Thank you so much.
11 This has been very valuable input. We are
12 so excited about the standing committees. I
13 know your sentences are two to three years.

14 (Laughter)

15 MS. MUNTHALI: It gives us an
16 opportunity to really engage with you and to
17 share ideas and move forward on population
18 health.

19 And we just wanted to really thank
20 Sarah and Tom for their leadership. You've
21 done a great job. The entire committee has
22 done a great job.

1 We'd also like to thank the
2 developers, NCQA. We'd like to thank AHRQ
3 and also the Dental Quality Alliance. And
4 everyone else who's listening, thank you for
5 participating.

6 DR. MCINERNEY: Thank you to the
7 committee. You really were a great group,
8 very cooperative, collegial and a lot of
9 good input. And thanks to the staff for all
10 of their help in making this be so
11 successful.

12 (Whereupon, the foregoing matter
13 went off the record at 3:01 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Health and Well Being
Steering Committee Meeting

Before: NQF

Date: 04-30-14

Place: Washington, DC

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