NATIONAL QUALITY FORUM

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HEALTH AND WELL-BEING-PHASE 2
STANDING COMMITTEE

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WEDNESDAY
APRIL 22, 2015

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:07 a.m., Thomas McInerny and Amir Qaseem, Co-Chairs, presiding.

PRESENT:

THOMAS McINERNY, MD, American Academy of Pediatrics, Co-Chair
AMIR QASEEM, MD, PhD, MHA, American College of Physicians, Co-Chair
CHISARA N. ASOMUGHA, MD, MSPH, FAAP, Centers for Medicare and Medicaid Services *
MICHAEL BAER, MD, AmeriHealth Caritas Family of Companies *
RON BIALEK, MPP, CQIA, Public Health Foundation
JUAN EMILIO CARRILLO, MD, MPH, New York-Presbyterian
ERIC FRANCE, MD, MSPH, Kaiser Permanente Colorado
RENEE FRAZIER, MHSA, FACHE, Healthy Memphis Common Table
CATHERINE HILL, DNP, APRN, Texas Health Resources
RONALD INGE, DDS, Western Dental Services
DAVID KROL, MD, MPH, FAAP, Robert Wood Johnson Foundation *
MARGARET LUCK, SD, Mary's Center for Maternal and Child Care, Inc.

PATRICIA McKANE, DVM, MPH, Michigan Department of Community Health
AMY MINNICH, RN, MHSA, Geisinger Health System
JACQUELINE MOLINE, MD, MSc, North Shore LIJ Health System
MARCEL SALIVE, MD, MPH, National Institute on Aging
JASON SPANGLER, MD, MPH, FACPM, Amgen, Inc.
MIKE STOTO, PhD, Georgetown University
ROBERT OTTO VALDEZ, PhD, RWJF Center for Health Policy
ARJUN VENKATESH, MD, MBA, Yale University School of Medicine

NQF STAFF:

MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Measurement
ADEELA KHAN, MPH, Project Manager
ELISA MUNTHALI, MPH, Senior Managing Director
KAITLYNN ROBINSON-ECTOR, MPH, Project Analyst

ALSO PRESENT:

MARY BARTON, MD, MPP, NCQA
CHRISTINA BETHELL, PhD, MPH, MBA, Child and Adolescent Health Measurement Initiative
SEPHEEN BYRON, MHS, NCQA
JIM CRALL, DDS, ScD, DQA
SHERYL DAVIES, Stanford University
JILL HERNDON, DDS, DQA
CAITLIN MURPHY, MPH, Child and Adolescent Health Measurement Initiative
ROBYN NISHIMI, PhD, NQF Consultant
DIPTEE OJHA, PhD, MBA, DQA
ROBERT REHM, MBA NCQA
JONATHAN SHAW

* Present via teleconference

C-O-N-T-E-N-T-S

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

8:07 a.m.

MS. MUNTHALI: Thank you very much and welcome everyone. And sorry for the delay.

My name is Elisa Munthali. I'm with the National Quality Forum. I'd like to welcome you to the Health and Well-Being In-Person Meeting. And this is to review Phase 2 Measures.

But before I get into some housekeeping, I would like to turn it over to the Co-Chair, Tom McInerny for some welcoming remarks as well. Tom?

CO-CHAIR McINERNY: Good morning. Welcome everybody to lovely Washington, D.C. and the National Quality Forum, Health and Well-Being Committee Meeting.

And I want to thank the organizers, the NQF folks who have put this together in such a fine fashion for us to make it very usable friendly -- friendly for us to work on this and come up with some hopefully, approvals for these different measures.

Now I'm going to turn it back over to Elisa for further information.

MS. MUNTHALI: Thank you, Tom. I just wanted to mention that the other Co-Chair, Amir, is coming from Canada. I think his flight arrived at 7:40 today. So he'll be a little bit late, but he will be here.

We just wanted to let everyone know that's in the room, that the restrooms are just to the right of the elevators. We also have web access. So Kaitlynn, if you can pull up the web link.

So if you have your laptops and phones, the WiFi connection, the user name is guest, and that's lowercase. And the password is NQF, uppercase Guest, altogether, one word.

And we ask that you please mute your phones while you're in these deliberations. We want to make sure that we have lively and focused discussion.

And we also wanted to remind you that these meetings -- this meeting is being recorded

and transcribed. We have our court reporter to the right in the corner. So please remember when speaking, to use your microphones.

So with that, I will turn it over to our Senior Vice President, Nancy Wilson, who will go through Introductions and Disclosures of Interest.

DR. WILSON: Thank you, Elisa. Welcome everyone, our General Counsel, Ann Hammersmith could not be with us this morning, so I'm going over the disclosure of interest forms with you.

You received a disclosure of interest form before you were named to this Committee. And in that form we asked you about a number of your activities.

And today we're going to ask you to orally disclose any information you provided that you believe is relevant to the subject matter before the Committee. This disclosure process also acts as our introduction for the Members of this Committee.

It's not necessary to summarize your

resume. We're only interested in the disclosure of interest that is directly relevant to the work before this Committee.

And we're especially interested in grants, research or consulting. But only if it relates to the subject matter.

Just a couple of reminders, you sit on this group as an individual. You do not represent the interest of your employer or anyone who may have nominated you.

And the only thing I would mention is that we're not just interested in disclosure activities where you were paid. For example, you may have participated as a volunteer on a committee where the work was relevant to what we're doing today.

So we're looking for you to disclose those types of activities as well. But again, only if relevant to the subject matter.

Now, just because you disclose that does not mean that you have a conflict of interest. We do oral disclosures in the interest of openness

and transparency.

So we'll go around the room. I'm going to start with our Co-Chair who is with us now. And please tell me your name, who you're with, and if you have anything to disclose.

And then once we've gone around the room here, I'll turn to a couple of Committee Members who are joining us on the phone. So, Doctor, if you would like to start please?

CO-CHAIR McINERNY: Sure. Thomas McInerny. And I am a member of the -- Fellow of the American Academy of Pediatrics. And I have nothing to disclose.

DR. WILSON: Thank you. Dr. Carrillo?

MEMBER CARRILLO: Good morning, Emilio Carrillo, New York Presbyterian. I have nothing to disclose. Thank you.

MEMBER FRANCE: Good morning, Dr. Eric France, Kaiser-Permanente. I have nothing to disclose.

MEMBER BIALEK: Good morning, Ron Bialek, Public Health Foundation. And I have

nothing to disclose.

MEMBER MOLINE: Good morning, Jacki Moline, North Shore LIJ Health System. I have nothing to disclose.

DR. SPANGLER Good morning, Jason Spangler from Amgen. Nothing to disclose.

MEMBER VENKATESH: Good morning, Arjun Venkatesh from Yale University. The only potential disclosure I have is that I believe I served as a technical expert panel member for PQI 10 in at least one or two versions ago. This was greater than probably five to six years ago.

DR. WILSON: Thank you.

MR. VALDEZ: Hi, good morning. This is Robert Valdez. And I have nothing to disclose. I'm from the University of New Mexico.

DR. WILSON: Thank you.

MEMBER SALIVE: Marcel Salive, NIH, representing myself. And no disclosures.

DR. WILSON: Thank you.

MEMBER STOTO: I'm Mike Stoto from Georgetown University. I have served recently on

two technical advisory panels, having one for AHRQ, one for CMS dealing with measurement issues.

But none of the ones that we're considering have come up. But they're in the same general area.

DR. WILSON: Thank you.

MEMBER HILL: Can you hear me now? Catherine Hill with Texas Health Resources. I have nothing to disclose.

DR. WILSON: Thank you.

MEMBER FRAZIER: Renee Frazier, Common Table Health Alliance. The only disclosure would be as the project director for Aligning Forces for Quality.

We do work on measurement. And some of those measures associated with well-child care, which are being discussed today. So I would like to disclose that.

DR. WILSON: Thank you.

MEMBER MINNICH: Amy Minnich from Geisinger Health System. And I have nothing to disclose.

MEMBER McKANE: Patricia McKane, Michigan Department of Community Health. And I have nothing to disclose.

DR. WILSON: Thank you. And I think on the phone we have a couple of Committee Members. Dr. Krol, are you with us on the phone please?

MEMBER KROL: I'm here, yes. This is David Krol. Hi everyone. I'm with the Robert Wood Johnson Foundation. I have nothing to disclose.

DR. WILSON: Thank you. And I think Dr. Baer, are you also with us on the phone today?

(No response)

DR. WILSON: Are you on mute Dr. Baer?

(No response)

DR. WILSON: Okay.

OPERATOR: He has not joined yet.

DR. WILSON: Thank you so much, operator. Do we have any other Committee Members who have joined that I did -- whose names I did not call?

(No response)

DR. WILSON: Okay, thank you everyone for those disclosures. And I'd like to remind you that if you believe you might have a conflict of interest at any time during a meeting, please speak up. You may do so in real time or you can approach the Co-Chairs or any of the NQF staff.

If you believe a fellow Committee Member may have a conflict of interest or is behaving in a biased manner, you may point this out during the meeting. Or again, approach the staff.

We don't want you to sit in silence if you think there's any irregularities due to conflict of interest or bias. So, please speak up.

Do you have any questions based on anything you've heard from your fellow Committee Members so far?

(No response)

DR. WILSON: Thank you very much for your time.

MS. MUNTHALI: Thank you Marsha. And I also wanted to take this opportunity to introduce the other members of our project team.

We have Adeela Khan, who is the Project Manager. Kaitlynn Robinson-Ector, who is a Project Analyst. And Robyn Nishimi, who's serving as a consultant on the project.

So with that I'll turn it over to Kaitlynn.

MS. ROBINSON-ECTOR: Hello everyone, I'm Kaitlynn. And today I'll be going over the project introduction and overview of the evaluation process.

So today's meeting objectives are as follows. To evaluate the seven measures that are under review for NQF endorsement.

To review the draft updated standard specifications for pneumococcal vaccinations. And to identify measure gaps for Health and Well-Being portfolio measures.

NQF is working to improve committee meetings based on input from a variety of stakeholders. And we have a few changes to our meeting process.

We recognize that we are fortunate to

have the measure developers present. And we will be asking them to briefly introduce their measures as they come up for our discussion.

Selected workgroup representatives will then discuss the measures in relation to the measure criteria. We have also provided a designated place for the developers at the main table during our discussion.

The developers will be able to discuss their measures. Here it will be more easily for them to respond to Committee questions and to correct any misunderstandings about their measures during our discussion.

As is the case with Committee Members, developers may put their cards up to indicate when they respond to questions raised. Or correct any statements about their measures.

During measure evaluation, Committee Members often offer suggestions for improvement to these measures. These suggestions can be considered by the developer for future improvements.

However, the Committee is expected to evaluate and make recommendations on the measure per the submitted specifications and testing.

Committee Members act as a proxy for NQF membership. As such, this multi-stakeholder group brings varied perspectives, values and priorities to the discussion.

Respect for differences of opinions and interactions among the Committee Members and measure developers are expected.

The work group call and Committee meeting agendas are typically quite full. All Committee Members, Co-Chairs, developers and staff are responsible for ensuring that the work of this meeting is completed during the allotted time.

During this discussion the Committee Members should be prepared, having reviewed the measures beforehand. Base evaluation and recommendations on the measure evaluation criteria and guidance.

Remain engaged in the discussion without distractions. Attend the meeting at all

times expect for breaks. Keep comments concise and focused.

Avoid dominating the discussion and allow others to contribute. And lastly, to indicate agreement without repeating what has already been said.

Committee Members serve two year to three year terms. Work with NQF staff to achieve project goals. Review all the measures within the given project.

Evaluate each measure against each criterion. Make recommendations to NQF membership for endorsement. Respond to comments submitted during their review period.

Respond to any directions from the CSAC. And also oversee the portfolio of Health and Well-Being measures.

These are the eight steps that take place during NQF's consensus development process. We are currently in the standard of review step.

During this step, the Committee will review measures within the given project. And

decide whether these measures will be recommended for endorsement or not.

These are the criteria that the Committee will use today to evaluate each measure. And I will now be going over the portfolio review.

Last year the Standing Committee began with 15 measures. Seven of which were newly submitted to NQF. And eight of which were undergoing maintenance review.

Measure 0280, Dehydration Rated PQI 10, was deferred to this current phase of Health and Well-Being. After the Committee evaluation phase, 13 measures were recommended for endorsement, with measure 2518, Care Continuity Dental Services being designated as consensus not reached.

During the CSAC, 13 measures were recommended for endorsement. While measure 2518 was not recommended for endorsement based on the evidence not being strong enough.

This is a complete list of the measures that were endorsed by NQF's Board of Directors,

Executive Committee. And during this phase of Health and Well-Being, the Standing Committee discussed these overarching issues.

Evaluation of performance measures for oral health, dental and oral health outcome measures, dental versus oral health services, and accountability and population health measurement.

These are the seven measures that are being evaluated during this second phase of Health and Well-Being. The seven measures under review for NQF endorsement and consideration assess population health and health and well-being.

The Committee will review both endorsed measures under maintenance annually submitted measures. Within this phase there are five maintenance measures that are being reviewed for endorsement consideration and two newly submitted oral health measures that are being reviewed for consideration.

I will now turn the presentation over to Adeela.

MS. KHAN: Before we start, I just

wanted to -- I think Michael Baer is on the phone now. Is that correct?

(No response)

MS. KAHN: Are you on mute?

(No response)

MS. KAHN: Cathy, can you just --

OPERATOR: He hasn't joined the phone lines yet.

MS. KAHN: Oh, all right. Thank you. Can you let us know when he joins, please?

OPERATOR: Yes, ma'am.

MS. KAHN: So, I'll actually turn it over to Tom to start the meeting. But if you NCQA, if you'd like to come up and have a seat at the table.

CO-CHAIR McINERNY: Thanks for the NCQA folks, would you like to introduce yourselves, please?

MR. REHM: Hi, I'm Bob Rehm. I'm the Assistant Vice President, Performance Measurement and have been with NCQA for about I've years.

And in just a few minutes, Sepheen Byron

will be taking my seat because she's our measure lead. But she's been delayed by the metro.

DR. BARTON: And I'm Mary Barton, Vice President for Performance Measures at NCQA.

CO-CHAIR McINERNY: Good. Thank you very much for coming. So the first measure that we have to consider is number 1407, Immunizations for Adolescents.

DR. BARTON: If I may, give a very short intro here. The immunizations for adolescents measure puts several measures -- several immunizations together in one measure to make sure that as children age through -- towards adulthood, they're still getting high quality care and recommended care from their providers.

And of course the Advisory Committee on Immunization Practices has recommended these --

CO-CHAIR McINERNY: Please get a little closer to the microphone. Thank you.

DR. BARTON: Of course the Advisory Committee on Immunization Practices, which the CDC funds and runs, has recommended these

immunizations for adolescent patients.

CO-CHAIR McINERNY: All right. This now is open for discussion. Would some of the folks from the team that looked this over, would they like to start?

Jane Chiang is not here, right? Not here. How about Juan Carrillo? Later? All right. Catherine Hill? Would you like to --

MEMBER HILL: I supported the measure in review is my only comment.

CO-CHAIR McINERNY: Do we want to go through each of the -- you know, each of the important steps? The evidence and the acceptability, scientific acceptability?

You voted yes on all of those different steps. You have your algorithm in your packet?

MEMBER HILL: Right. I do have the algorithm packet.

CO-CHAIR McINERNY: And you voted pass on each of those? All of those?

MEMBER HILL: Um-hum. I did.

CO-CHAIR McINERNY: Okay.

MEMBER HILL: I did.

CO-CHAIR McINERNY: Okay. Oh, didn't get it? Try again Pat. There you go, okay.

MEMBER McKANE: Okay, we got it. I think, you know, this is one I reviewed and then I was reading -- or sorry.

I reviewed this measure as well. And I also was reviewing the comments last night. So I don't know if it would -- if you want to talk about some of the things that people brought up right now?

Or do we want to go as we go through? Would it make more?

MS. KHAN: So why don't we start off with the evidence first. That's the first criteria.

MEMBER McKANE: Okay.

MS. KHAN: If there's anything related to the evidence that you all want to bring up, let's discuss that first.

MEMBER STOTO: Can I just ask, is there someplace where we can see what the comments that people made in the first review?

MS. KHAN: Yes. If you go onto our site, all of the documents are there. If you want, I actually have them on a flash drive, I can bring them over to you too.

MEMBER STOTO: I'm sorry, where do we go exactly in the site? I'm on the SharePoint site now. But --

MS. MUNTHALI: So, this was sent out. We can resend the link to everyone that has all of the input on all of the measures from the Committee Members.

So, NCQA, if you can bear with us for just a couple of minutes while we get everyone on the same page.

MEMBER STOTO: Okay. So I downloaded those documents a couple of days ago. It's on the 16th or so? Okay.

MS. MUNTHALI: We also have some flash drives I think that Kaitlynn will be handing out.

MEMBER KROL: This is David. I'm looking at the measure worksheets. Is that the correct place to be looking? That looks like that

has all the comments on it.

MS. MUNTHALI: That is. So perhaps if there's anyone, we did things a little differently because we had fewer measures this time around.

So we have more people assigned to each measure. So perhaps for this measure, if there's anyone who was assigned to this, Emilio, that has anything to add to the discussion to get it started, I would really appreciate that.

MEMBER CARRILLO: Well, in the past, having reviewed quite a number of measures with NQF, normally there's someone, one or two people who are assigned to do an in-depth review. And then make a detailed presentation going through all the steps.

And I'm not sure whether -- with it not. I mean, that's --

MEMBER HILL: This particular group did not assign someone to present. Although I have all the comments in front of me, it would be pretty arduous to -- I didn't write a summary paragraph, so.

MS. MUNTHALI: And that's fine. I think the information you gave was helpful. Perhaps if there were others that had similar thoughts as Cathy? Were in agreements or descending views about the measure. And wanted to talk about issues about the measure.

This would be the opportunity to do that. And we would like to go in the order of the criteria as Adeela mentioned before. But any general impressions before we get into the individual criteria since quite a few people were assigned this measure.

MEMBER HILL: I think part of the quandary for us here, was this is a maintenance measure. And we were trying not to repeat anything.

And so, the endorsement was a little more straightforward for this particular measure.

MEMBER STOTO: If I can add to that. I felt the same thing. That in this case, it was endorsed and I didn't see any reason why that should change.

And I don't know whether there is something, there's some change in specifications or something like that, that would cause us to.

MEMBER SALIVE: I think I also concur. But what I would add, is I believe that there's been some newer meningococcal vaccines. But I don't think that they've been recommended yet.

But there's -- but overall, I was, you know, very -- I had no issues with this measure.

CO-CHAIR McINERNY: Go ahead, Emilio.

MEMBER CARRILLO: Yes, I don't have any specific detailed comments in review. I similarly do not have any issues with the measure.

CO-CHAIR McINERNY: Eric?

MEMBER FRANCE: This is a measure that's been used for many years in health plans across the country. It's managed too, as a quality improvement tool.

Organizations track the performance of this combined vaccination rate for 13 year olds. The evidence in support of the vaccines is strong.

The evidence that high rates of

vaccination lead to improved health outcomes I think is strong too for these particular conditions. Especially with the pertussis issue that we have across the country today.

I think the reliability and validity of the actual measurement itself is fine. So I think we're all a bit quiet because we see it as a very valuable metric that should go forward.

MEMBER HILL: Certainly from a -- from Texas' point of view, it's one of those indicators that we continue to see not be improvement at the rate that we would like with other indicators.

And we continue to work on it and see it come up when we have contract negotiations around value-based purchasing.

CO-CHAIR McINERNY: Arjun?

MEMBER VENKATESH: I would agree with everything that folks here said in the sense that I think it has a strong evidence base. There's clearly variation. The measure's already endorsed.

The only question I would raise is, and

I am an emergency doc, and I take care of adults. So I am completely outside of my space here when I ask this.

Is that, one of the -- some -- one of the Committee Members who reviewed this had raised a question about why the measure allows for both a tetanus toxoid vaccination in addition to a Tdap with pertussis?

And so since we're talking about evidence, I was just going to ask the question, either of the developer or of others on the Committee who may be experts, around where the evidence base is with respect to one of those -- well, with respect to the Tdap over the tetanus toxoid?

Is there ac -- are those two always just kind of put together in guidelines and in recommendations? Or is there actually a difference between those that would suggest that, you know, from this Committee, we should recommend improving the measure by focusing on one?

MEMBER SALIVE: I think it's an issue

where this is the booster shot. They've had four or five shots earlier in life.

And so it's really not, I think, the crucial time. You know, there are issues with the pertussis disease, as someone mentioned. But I think the evidence base you can get on, you know, the fifth shot for somebody is, you know, a pretty high bar.

So I don't -- you know, I don't have any strong feelings one way or the other on that.

CO-CHAIR McINERNY: So, I was thinking that same issue myself. I realize that we're voting on the measure as it's written. And that it allows both either Tdap or Td.

However, I would recommend to NCQA that they should look at the evidence closely. In my mind, it's much more important that the adolescents get a Tdap because the problem with pertussis and the waning of immunization immunity for pertussis is a significant one.

And we know that many adolescents who have not had a booster, are having pertussis or have

subclinical cases. But they are infecting others who -- particularly infants who are unimmunized.

And we're seeing some increase in pertussis in the country. And I think as a result of that, I'm seeing recommendations that the Tdap booster is much more important than a Td.

So, in the future, I'd like to ask NCQA to switch from Td. Eliminate that and do Tdap only if the evidence agrees with my impression.

Any other comments on -- yes, Robert?

MR. VALDEZ: And in the same vein, I request that the evidence for HPV also be included.

CO-CHAIR McINERNY: Yes. That's also on my --

MR. VALDEZ: Because that's a more modern vaccination that clearly has recommendations for this same particular age group. That's of great importance and is not part of this older measure.

CO-CHAIR McINERNY: Yes. I agree. And again, I would recommend NCQA add HPV. I think the evidence for girls is very strong.

But also, I've seen some recent reports that the evidence of providing HPV for boys also, has some -- is very cost effective. It's certainly safe and probably, boys and girls, we should add HPV.

I don't know whether that should be a separate measure or part of this measure. But I'd leave that up to NCQA to research that, please.

Yes?

MS. BYRON: So just on that note, for HPV, we do have a measure for HPV vaccination for female adolescents right now. And we are currently looking at that measure.

CO-CHAIR McINERNY: Oh, great.

MS. BYRON: And adding -- we're looking at the feasibility of adding males to that measure. And then we will consider actually whether to merge the measures or keep them separate.

But that's ongoing. So thank you for raising that.

CO-CHAIR McINERNY: Thank you. Comment? Yes?

MEMBER FRANCE: Just to clarify of course, that the Tdap/Td option is the transitional issue of going from an old vaccine to a new vaccine with the Tdap, historically new. Probably eight to ten years old now.

So, I would imagine a future day when the CDC and AFP, Academy of Family Practice, have a harmonized schedule that specifically recommends Tdap. But they might move away from this Td as an option.

So, I -- once we're there as a country, I think that makes the best time for us to move to Tdap. I would support a Tdap measure rather than a Td option.

CO-CHAIR McINERNY: Any other discussion on this measure?

(No response)

CO-CHAIR McINERNY: All right. I guess we're ready then to vote on whether this measure should be approved to be sent up along the -- I forget the next step from -- where it goes from here.

MS. ROBINSON-ECTOR: Okay. So I just wanted to go over the voting procedure really quickly. So when you're voting, make sure you're pointing your clicker at me or this laptop.

And also, it takes six seconds for your vote to register. And each number on your keypad correlates to an answer on the voting slides.

And you can check your vote by the number that shows up on your keypad. And if you want to revote, you can simply press the new number that you want to press and it will cancel out your previous vote.

MEMBER KROL: And will you reach out for a verbal vote from those of us on the phone?

MS. ROBINSON-ECTOR: Yes. I was just going to say, for those of you on the phone, I think Chisara, Michael and David will reach out to you on the phone.

MS. MUNTHALI: And just as a matter of order. Before those on the phone vote, we do need you to introduce yourself and to disclose any interests that you may have, just before we take

a formal vote.

So I will turn it over to Marsha Wilson.

DR. WILSON: Thank you, Elisa. This is Marsha Wilson. And we've had a couple of new Committee Members join us on the phone.

So Dr. Baer, earlier today we went around the room and did an oral disclosure of any potential activities related to the subject matter at hand today. So if you could please introduce yourself, where you're -- who you're with. And if you have anything that you need to disclose at this time.

Dr. Baer?

MEMBER BAER: Can you hear me now?

DR. WILSON: Yes, sir.

MEMBER BAER: All right. Well, I apologize for not being connected somehow on my computer before. But -- anyway, I'm Dr. Michael Baer. I'm with AmeriHealth Caritas. And I have no disclosures.

DR. WILSON: Thank you very much. And I think we have another Committee Member on the

phone. And I am not going to do well pronouncing your last name. Asomugha?

Dr. Asomugha, please, if you could introduce yourself, where you're from. And if you have any disclosures.

MEMBER ASOMUGHA: Yes. Good morning. My name is Chisara Asomugha. And I apologize for not being in the room. An illness has gotten me.

But, I am working for CMS and I'm a Senior Advisor there. And I have no disclosures.

DR. WILSON: Thank you so much. And here with us in the room at National Quality Forum I think Dr. Chiang has joined us.

And if you could please introduce yourself. Turn on your microphone, introduce yourself, where you're from. And let us know if you have any disclosures.

DR. CHIANG: I'm Jane -- can you hear me?

DR. WILSON: Yes.

DR. CHIANG: I'm Jane Chiang and I work at the American Diabetes Association. And I'm a

pediatric endocrinologist.

DR. WILSON: Thank you so much. And do we have anyone else who has not --

DR. CHIANG: I have no disclosures.

DR. WILSON: Oh, thank you so much Dr. I cut you off rather quickly there.

Anyone else who did not have a chance to do the oral disclosure?

(No response)

DR. WILSON: Thank you very much.

MS. ROBINSON-ECTOR: Okay, yes. So the vote is now open for evidence for measure 1407.

MS. KHAN: QQC refers to the quality, quantity and consistency of the evidence. And Robyn can speak more to that, I believe.

MEMBER STOTO: Was that submitted in this case?

DR. NISHIMI: Yes. It's in the measure submission form.

MEMBER STOTO: Okay.

MS. KHAN: And David, Michael and Chisara, if you'd like to let us know what your vote

is? It's high, moderate, low, insufficient evidence or insufficient with an exception.

MEMBER KROL: This is David Krol, high.

MEMBER ASOMUGHA: Do we do that into the chat box, or do you want us to say that out loud?

MS. KHAN: You can do either one.

MEMBER ASOMUGHA: Okay. All right.

MS. KHAN: Michael, can you clarify? Okay, thank you.

MEMBER BAER: Sorry about that.

MS. KHAN: It looks like we're still waiting on two votes. So if you could just make sure.

MS. ROBINSON-ECTOR: All the votes are in. And voting is now closed.

CO-CHAIR McINERNY: And vote what?

MS. ROBINSON-ECTOR: Is closed.

CO-CHAIR McINERNY: Oh, okay.

MS. ROBINSON-ECTOR: Okay. So nine voted high. Seven voted moderate. Zero voted low. And Zero voted insufficient. And zero voted insufficient evidence with exception.

MS. KHAN: Are there any comments on the performance gap? Or does the Committee feel that we should just move to a vote?

CO-CHAIR McINERNY: I think we can -- an overall vote, you mean? Or for each individual?

MS. KHAN: For each individual.

CO-CHAIR McINERNY: Okay.

MS. KHAN: Okay.

MS. ROBINSON-ECTOR: Voting for performance gap for measure 1407 is now open. And anyone who's on the line, feel free to say your vote.

Okay. It looks like we have all the votes.

MS. KHAN: Chisara, we're still waiting on your vote.

MEMBER ASOMUGHA: It didn't go through? Oh.

MS. KHAN: No.

MEMBER ASOMUGHA: Okay, let me try again, sorry.

MS. ROBINSON-ECTOR: Okay. All the

votes are in. For performance gap, 15 voted high, two voted moderate, zero voted low and zero voted insufficient.

MS. KHAN: So at this time we're going to move onto scientific acceptability. Does anyone in the Committee have any questions about any of the testing that was provided, reliability of testing specifications? We'll start with reliability.

(No response)

MS. KHAN: Okay. If there are no comments, then let's go ahead and take a vote on reliability.

MS. ROBINSON-ECTOR: Voting for reliability is now open. Okay. It looks like we have all the votes in.

For reliability, 15 voted high, two voted moderate, zero voted low, and zero voted insufficient.

MS. KHAN: Moving onto validity. Are there any comments from the Committee on validity of the measure or any of the testing that was

provided?

(No response)

MS. KHAN: Okay. Hearing none, let's move onto vote for validity.

MS. ROBINSON-ECTOR: Yes, voting is open.

All the votes are in and voting is now closed. For validity, 13 voted high, four voted moderate, zero voted insufficient, and zero voted low.

MEMBER ASOMUGHA: Can you say one more time how many voted insufficient?

MS. ROBINSON-ECTOR: Zero.

MEMBER ASOMUGHA: Okay.

MS. KHAN: Are there any comments from the Committee on feasibility? That's the date generated during care and can the data collection be implemented.

(No response)

MS. KHAN: Okay. Hearing no comments, we can start the vote.

MS. ROBINSON-ECTOR: All the votes are

in and voting is now closed.

For feasibility, 14 voted high, three voted moderate, zero voted low and zero voted insufficient.

MS. KHAN: Okay. Are there any comments on usability and use?

(No response)

MS. KHAN: Okay. Hearing none, let's go ahead and vote on usability and use.

Chisara, we're waiting for your vote. Thank you.

MS. ROBINSON-ECTOR: All the votes are in. And voting is now closed.

16 voted high, one voted moderate, zero voted low and zero voted insufficient information.

MS. KHAN: Moving onto the overall vote for endorsement. Does the measure meet NQF criteria for endorsement? Are there any comments?

(No response)

MS. KHAN: Okay. Hearing none, we can go ahead and vote on overall suitability for endorsement.

MEMBER KROL: Can you just -- what are the options for answers for this?

MS. KHAN: One is yes and two is no.

MEMBER KROL: Okay.

MEMBER ASOMUGHA: Thank you.

MS. ROBINSON-ECTOR: All the votes are in. And voting is now closed.

So 17 voted yes and zero voted no. So for measure 1407 Immunizations for Adolescents, passes for overall suitability for recommendation for endorsement.

CO-CHAIR McINERNY: Right. Thank you very much. Now we can move onto our second measure, number 1392, Well-Child Visits in the First 15 Months of Life. Another NCQA developed measure that's been around for a few years. And we can open the discussion. Anybody from that subgroup that would like to speak about that?

MS. KHAN: Well, actually, let's turn it over to the developers.

CO-CHAIR McINERNY: I'm sorry, let the developers --

MS. KHAN: Yes.

CO-CHAIR McINERNY: I'm sorry, the developers need to speak first. I apologize.

MS. BYRON: Thank you. So this measure looks at whether or not children receive well-child visits in the first 15 months of life. It's very similar to the second measure actually, which looks at well-child visits in the third, fourth, fifth, and sixth years of life. It looks at the well-child visit as a critical opportunity to administer vaccinations and provide anticipatory guidance. And also needed screenings according to the stage of life that the child is in.

And in many ways, it is viewed as an access measure to see if children are able to get into the healthcare system and receive the necessary well-child visits to get these services. It's used in the Medicaid core set for children as well as other programs including NCQA's own programs. It's used widely by states. And we have received feedback from states that it is a very

useful measure. And it's also being considered in other programs, such as the Quality Rating System.

MS. KHAN: So let's talk about evidence. Are there any comments from the Committee on the evidence that was provided?

CO-CHAIR McINERNY: Before we do that, could we introduce Margaret Luck, please?

DR. WILSON: Hi Margaret. I'm Marcia Wilson, Senior Vice President for Quality Measurement here at NQF. And we did oral disclosures for all the Standing Committee Members when we came in. So, if you would be so kind as to introduce yourself, where you're from. And if you have any activities, either paid or unpaid that are related to the subject matter that we're going to be talking about today. Thank you.

MEMBER LUCK: My name is Margaret Luck. I work with Mary's Center for Maternal and Child Care, a federally qualified health center here in the District of Columbia. And I have no disclosures.

DR. WILSON: Thank you so much.

MS. KHAN: Thank you, Margaret. Are there any comments on evidence? You can just raise your tent and we'll call on everyone. Arjun?

MEMBER VENKATESH: So I think I was on the group that had -- got us in this measure. And so I was just in review of the measure. And kind of the guidance that we got, I think that it would rate probably, I think, moderate based on the evidence criteria. Simply because the main citations for this are recommendations from AAP and Bright Futures, which are based on expert consensus.

And probably the key thing to remember here is that we're really trying to evaluate the evidence base of what is the kind of desired numerator and denominator of the measure, which is a number of visits over 15 months. And so probably that's not something that's going to be extensively studied in a randomized fashion, or even in a lot of causal ways to look at how each incremental one visit links outcomes. But it sounds like it has face validity, it has expert consensus. And so,

I think it's probably rated a moderate.

MR. KHAN: Mike?

MEMBER STOTO: What I would say is consistent with that. I guess the one extension is it strikes me that the evidence that's cited talks about the importance of developmental screening and following up on that. And that having a visit doesn't necessarily mean that all those good things will happen. And then I don't imagine someone's going to do an RCT of this either.

I'm not sure -- I don't think we're going to get better than that. But I think that that's the problem, is that we can measure visits, not the content of the visit so easily.

MS. KHAN: Please, Ron?

MEMBER BIALEK: Yes, I had some concerns with the specificity of the measure, the way it was laid to as well as the evidence around it. For instance, why six, seven or eight visits? It wasn't real clear to me. The term PCP used in there in some circles refers to primary care providers. It wasn't clear in here if it was only

physicians that were seen here for the well-child visit, or if it was broader.

The sick-child visit as an opportunity for some of the well-child care wasn't considered here. And when we look at the disparities issue and we consider that, you know, families who the one parent family working two jobs and unable to take the child for a well-child visit may need to have well-child care during the sick visit.

So, a variety of those items I didn't feel were discussed in here and provided as evidence that suggested that this measure, with the number of visits specified, and what was considered in those visits, being supported by what was presented.

MS. KHAN: Mary or Sepheen, did you want to respond to any of those comments?

MS. BYRON: Sure. So in terms of the number of visits, that actually follows the American Academy of Pediatrics periodicity chart. So where they say, you know, have a visit at one month, two months, three months.

So we actually count up the number of visits that would have between zero and 15 months, and that corresponds to the different rates. And it's actually broken up so that we can see, you know, how many people had five versus had zero. States actually ask to be able to see that level of specificity, to be able to determine whether or not some is getting zero or three or four. So, that's why we've kept the measure that way.

In terms of the content, yes, it is true that this looks at the visit counts. It really, think of it as more of an access measure, where it's looking to see if children are accessing care. In the hybrid specification, we do require certain components that would alert us to this being a well-child visit. So a health history, physical developmental history, mental developmental history, physical exam, health education or anticipatory guidance. And so in that way, we are trying to distinguish from just a sick visit. And did I miss any of your other comments?

MS. KHAN: Arjun and then Jacki.

MEMBER VENKATESH: I guess, since it's coming up, I'll ask the question. And so it builds up what Ron asked. And I think it's something you probably have already tested. And so, in patient populations that were like say the Medicaid plans, or those that are vulnerable, did you find that they had an equal number of visits but a higher number of sick visits? Or is it that they have fewer visits and fewer well-visits?

Because I think that it speaks to that issue then about this validity question. Of not knowing actually what the content of a visit is. And the idea that in reality, what is sick and what is well probably do occur at the same time frequently.

MS. BYRON: Yes. And I don't recall the data for that, but I do know we did take some great pains to be able to specify what would be a well-visit versus a sick-visit. And that is something that we deal with every day through our policy clarification support system. When people are writing in and saying, I'm seeing this visit.

Here are the things that happened during the visit.

You know, can I count this as a well-child visit or not? And so our staff are trained to be able to respond to them and say, no, that's a sick-visit. No, that's a -- yes, that is a well-child visit. Because like I said, they are looking for these key bullet points here that we -- that actually align with the guidelines in terms of what qualifies and is defined as a well-child visit. And so, we do a lot of work to help people distinguish between those two types.

MS. KHAN: Jacki?

MEMBER MOLINE: The question I have was, if the recommendation is for eight, why are we looking for six? And I couldn't find anything that told me why, if we're really looking to see does someone follow all the guidelines, why isn't the measure also looking at eight?

MS. BYRON: Yes, that's a good point. And what we've tried to do is collect the data in a way that can be broken down. And so, you could answer that question of, you know, did you get six?

Or did you get eight, by looking at the different rates. And we could eliminate the rest of the rates to say, did you get two?

But, as we said, the users were really the ones who pushed us to keep some of that granularity so that they could see, okay, well if you're not getting eight, exactly how many are you getting? Is it zero? Or is it partial? You know, when are kids accessing the system?

DR. BARTON: If I could just add to that. I think the -- sometimes the difference between a guideline and a measure has to include life. And so the, you know, the issue about the AAP guidance and Bright Futures, with the periodicity of what is supposed to happen, what you want to seek for happening. What you want to build reminder systems in your practice to ensure that that happens.

And yet, if we're going to measure, you know, if we're going to measure the culpability of the plan to make that happen, you know, what about the kid who comes in, you know, at six months --

15 months and two days for their eighth visit?

And so, having six plus be the top of this measure was in recognition of the fact that for the real life circumstances of any practice, or any health plan which accumulating data for many practices, they would be -- it would find it useful to have a measure that gave a little at the edge, as it were, to represent a little more realistic picture that there was still a lot of quality to drive using this measure. Right?

If this were topped out, then I would say absolutely, we should go back and look at this and try to make it, you know, raise it to a higher bar. But I think that -- and would you agree, this is something that State Medicaid programs have told us is a valuable tool to drive quality improvement as it currently is specified.

CO-CHAIR McINERNY: Eric?

MEMBER FRANCE: So, I have to admit that for me I've ignored this metric as a performance measure over the years, because it seemed non-evidenced based about the number of

visits. And the outcomes of how it's compared to other quality measures, where it felt much more evidence based and therefore something to be pursued. So, I have that sort of a framing before I jump in. I'm looking at our guidance for evaluating the clinical evidence.

And Arjun, I'm wondering if you might walk me through this. If you don't mind, to show me how we get to moderate evidence versus a low evidence? Or if we might, is it possible to put this up on the screen so that we could see it as a group?

MS. KHAN: Yes. Sure, we can pull it up.

MEMBER FRANCE: I'm happy to support it as moderate if he sort of can -- if you've seen this, or were you thinking about it from this perspective, Arjun, when you made that comment?

MEMBER VENKATESH: No.

MS. KHAN: So, just for those people who are on the phone, we're going to be walking through the algorithm for this measure, 1392. I

believe everyone in the room has a copy at their seat.

MEMBER KROL: That's algorithm one you're talking about?

MS. KHAN: Yes. Algorithm one.

MEMBER VENKATESH: This mic is blinking, does that mean that too many people have their mics on?

MS. KHAN: Yes.

MEMBER VENKATESH: Okay. I'm ready now. So I didn't use this chart directly. I used it just kind of having been around NQF and thinking through this a bunch. And so my understanding was that once you are at kind of face validity, and face validity could be accessed by expert consensus, that puts you in the moderate bucket. And so that's the mental rule I've always used in my head. But where is that on this? Yes, sort of where --

MS. MUNTHALI: Yes, and Arjun, that is correct. But we can walk through it.

MEMBER SALIVE: So, my rule of thumb is on if there's two guidelines that say it, that's

-- plus the summary that was sent last week from the NCQA lists actually some trials that did study this. So I mean, it's definitely in the moderate category. I don't think --

MEMBER FRANCE: I don't think there were trials showing the number of visits are associated with a quality of health. I did read it, yes. But I didn't -- I mean, it talks about a couple of different -- I'm actually okay with the measure, but maybe for other reasons.

You know, I think six visits in the first 15 months of life has other reasons that I would recommend it. A three day visit, a two week visit and then two, four, six and 12 months for shots gets you to six visits. So, but that isn't really about the evidence and the number of visits somehow improves developmental outcomes and so on.

So, -- and then I was trying to use this algorithm to see how it took me over to moderate. And it looked to me as if it was taking me to low. But, I'll defer to those who have done more of this.

MS. KHAN: Mike?

DR. STOTO: I think I can work us through to moderate. See if you agree. I mean, so, starting at the upper left, this is not an outcome measure. So we'd then go down to three. And then right about in the middle of three, it says answer no if the evidence is about something other then what is measured. And I think really the evidence is about the content rather than the number of visits.

As I said, that's my central concern. So that -- we go to no. So we're now down to box seven at the lower left. But then, I think that you can follow that across to yes. I mean to moderate, excuse me.

MS. KHAN: Are there other discussion points or thoughts from the Committee? Ron?

MEMBER BIALEK: Can I just have a clarification on, again, is it physician or provider? Primary care physician or primary care provider providing the well-child?

MS. BYRON: Right. And I believe it's provider. And you know, this includes, in the

state of California, an OB/GYN can count as -- I'd have to actually look at the codes.

MEMBER BIALEK: I mean, I think that's an important for the measure to be clear if we're talking about only physicians. And then I would go -- and if we're only talking about physicians, I go back to the expert opinion group that came up with this. And there are some biases that could be entered into that whole evidence base.

MEMBER STOTO: It's not defined in the worksheet.

MEMBER BIALEK: Right.

CO-CHAIR McINERNY: Well, I think if I am correct, this is based on administrative data, and that is what's submitted or billed to the insurance company. And you know, I think it may vary from state to state as to whether a -- if a nurse practitioner sees the patient, versus a physician. Sometimes that's identified, but sometimes the visit is attributed to the physician, not to the nurse practitioner.

So it's difficult to know whether the

patient actually saw a physician or a nurse practitioner. In my mind, it doesn't make any difference. Frankly, I think either one is perfectly acceptable. But it would be difficult. And I think the other point is that since it is based on administrative data, it's based on what -- whoever saw the patient checks off on the charge slip.

And you know, that -- it's possible they may say well, you know, this child was presented for a sick visit. By the time I did everything, I asked a couple of other questions, so I'm going to turn it into a well-child visit. In that case it would be counted, but I don't know that that's a big problem. I don't think that happens very often.

But, you know, here's all the problems that we have with administrative data. You know, and sometimes what's checked off on the charge slip, how the bookkeepers coded it, is another problem. And we know that sometimes they make mistakes. But you know, all in all, I think that's

a smallish problem. And more noise then real significant. Mike?

MEMBER STOTO: I don't have any problem with it being provider rather then physician. I think it probably should be. My only concern is that it doesn't say in the documentation.

MEMBER CARRILLO: Tom, I just want to echo what you said. Again, it could be medical residents who are being coded administratively as a physician. So really, there's no way to discriminate. And it's really a, I think, a moot point.

MS. KHAN: Sepheen, did you have a comment?

MS. BYRON: Oh, I was just going to confirm it is provider.

MEMBER STOTO: Okay.

CO-CHAIR McINERNY: Can we take a break for a minute? Amir has come in. And why don't you introduce yourself and talk about disclosure, please?

CO-CHAIR QASEEM: Good morning

everyone. First of all, let me apologize. I was supposed -- I was flying from Toronto this morning, had a meeting over there. And the flight of course as always, there was mechanical problems and it got delayed. So, sorry about that. And I don't have actually any financial disclosures. And is it sufficient? Thank you.

MS. KHAN: Does anyone have any more questions on evidence? Emilio, your card is up. Did you have -- okay. Are we ready to take a vote? Okay. Give us one second and we'll set up. Are you ready?

MS. ROBINSON-ECTOR: Yes.

MS. KHAN: Okay. Do you want to walk us through?

MS. ROBINSON-ECTOR: Sure. So voting for measure 1392 for evidence is now open.

Okay. So all votes are now in. And voting is now closed.

Sorry about that, if everyone could recast their vote.

MEMBER ASOMUGHA: Do you need us to

revote?

MS. ROBINSON-ECTOR: Yes, please.

MS. KHAN: I've got yours. You don't need to send yours.

MEMBER ASOMUGHA: Okay. Okay.

MS. KHAN: Everyone on the phone, we've got yours.

MS. ROBINSON-ECTOR: Okay. Yes, we're waiting for one more.

Okay. So, all votes are in. And voting is now closed.

MS. KHAN: Since we're having some technical difficulties, can we just take a hand vote, please?

So all those in for high, please raise your hand?

DR. WILSON: Your hands high please. More high, so you count. Thank you.

MS. KHAN: Yes, moderate?

Low?

Insufficient Evidence?

We're missing two votes. Can we get

one more round? I'm so sorry.

High -- for those of you voting high, please raise your hands.

Moderate?

And those of you voting low?

And insufficient?

Okay. We have two high, 14 moderate, three low and zero insufficient. So it's moderate. So, let's move onto performance gap. Any discussion from the Committee on performance gap?

CO-CHAIR QASEEM: And I'm just going from what I remember when I reviewed this measure. If I remember correctly it was 20 percent performance gap, right? Which means, essentially, 80 percent of the people are already doing it. So only 20 percent of the physicians were not doing this. Is that what it was, if I remember correctly?

So 20 percent was -- may it was insurers. And I think -- and you may be right. I think that Medicaid was probably 30, yes, something

along those lines, yes. 60 to 70 percent. 60 to 70 percent Medicaid, the performance measure was being met. And 80 percent was being met for commercial insurers.

MS. KHAN: Yes.

CO-CHAIR QASEEM: So what was your question so I understand? I mean, did the --

MS. KHAN: The performance gap. So, we just want to make sure is there enough of a performance gap that there is opportunity for improvement?

CO-CHAIR QASEEM: Yes. And that's what I have -- my point was. I mean, I don't know how you all -- it will be interesting to just hear for you and for my educational purposes, what do you consider a big performance gap versus -- and keeping in mind, that there are some performance measures -- since there were certain quality areas where the performance gap is huge right? So it's like 70 percent may not be getting done. Do you classify this as a big -- go ahead Mike.

MEMBER STOTO: I mean, you can think

about gap in a number of different ways. I think you're talking about overall, what performance is compared to what's desirable. But you couldn't compare different groups, and different plans, and all sort of stuff like that. In a way I think those second ones are more important.

CO-CHAIR QASEEM: So let's say if it becomes a PQRS measure, right, would you -- would you think that the burden/benefit of having a measure over 70 to 80 percent, it's already good quality care? Does it meet the criteria that you should include it and make it a PQRS measure eventually? Because once NQF endorses it, it can become a PQRS measure.

MEMBER STOTO: Well, I mean if --

MEMBER ASOMUGHA: Hi, this is Chisara. To answer your question, no. It would seem like it would top out pretty quickly. But, then going back to sort of the fundamental question of whether this is a good measure, is what's in my mind. So, I'm thinking sure, I can say that I've seen, you know, this child at 15 months of age the appropriate

number of times. But what's been the quality of care in there?

And if it's going to be a PQRS measure by which we're going to be paying somebody, I'd rather want to know the content, versus how many times, or the frequency. So, whether there's a gap or not, I'm like, it's still not getting at the meat of what quality of care really is. It's just numbers. And it's not really about content or quality.

MEMBER STOTO: But that's not what we were discussing. We're talking about performance gap. And if --

MEMBER ASOMUGHA: Right. But I'm just -- for what he just asked, I'm sorry, I don't know the person who was late, from Toronto. When he was talking about, you know, you got 80 percent of X providers in this system that are able to do this measure, I mean, okay, you're going to top out pretty soon. So to me it seems pointless for lack of a better word. If that's what I --

MEMBER STOTO: Well, if you have 80

percent in -- if you have 100 percent in 80 percent of the population and zero in the rest of the population, that would average --

MS. KHAN: Talk in the mic please.

MEMBER STOTO: Oh, if you have 100 percent in 80 percent of the population and zero in the rest of the population, that would give you 80 percent overall. And that's a big performance.

MEMBER ASOMUGHA: Right.

MEMBER STOTO: And then that's the kind of thing I think we should be looking for.

CO-CHAIR QASEEM: Catherine?

MEMBER HILL: Yes, I think the part -- as coming at this as a nurse practitioner, part of what we're looking to do is train our populations to establish this relationship and use it routinely. And it's real hard to measure later in life, if I think about my patients from birth to grave, I want to start them out and train them to have this relationship and a frequency of visits. So there's that kind of you know, meta way of looking at this measure too.

Even though 80 percent may be doing it that means 20 percent are not. And as subsequent generations come into our world, this is an important fundamental training mechanism for how to achieve good outcomes.

CO-CHAIR QASEEM: Well, the last person for --

MEMBER SALIVE: So, I mean, yes, I think it's a very important measure. And it's more integrative then as lot of our measures. It's not so, you know, real picky. I think that the point was made about that many of these visits involve getting various immunizations. But it goes beyond that too.

And so it's -- I think it's very encompassing. And this is one which I would be want to see drive high up towards 100 percent. So, you know, how big a gap is too big? You know, I mean 80 percent is still pretty far from 100 percent.

CO-CHAIR QASEEM: If I could just add one more thing. Michael -- Sepheen raised her card

for -- do you?

MS. BYRON: Oh, I was just going to point out that actually the mean for Medicaid, it's 50 percent. So when you're thinking 80 percent, that's the mean for commercial plans, health plans.

MEMBER KROL: Okay.

MS. BYRON: And, you know, I agree with others who have noted that depends on what you're looking at. I mean, if you look at the 10th or 25th percentile of plans, it's actually quite lower. You know, it's down to about 45 percent, looking at commercial. And then Medicaid, it's even lower. So, you know, I don't know that we can say across the board that 80 percent is the performance rate.

CO-CHAIR QASEEM: Go ahead.

MEMBER VENKATESH: So, I think as I'm thinking about this, the way I always frame this, in thinking about performance gap is, is there a gap with respect to what ideal performance is and where we are right now? And then the second one is around variation.

And so if we think about the first, where are we at with respect to ideal performance? And it's hard to interpret because what's reported in both kind of the initial summary as well as if you go down in the worksheets, is really percentages with six or more.

And we know that, you know, the six number is based on, like Mary said, around life. That's why it's not eight. And so, what I would have actually liked to see and what would help me understand this is, how different does the gap look or variation look at, if I change the threshold to five?

Because if I make the threshold five and all of a sudden that 77 percent commercial jumps to 90-95, and that 61 percent Medicaid jumps to 80, now I know that it is more a gap driven based on the threshold we set at six versus five.

And then the other question I have around variation is when I look down at the box plots that you guys have in the worksheet, again, it's with this outcome of six. It's not talking

about the other number of visits.

The variation is actually pretty small for the commercial population. The inner cortile range goes from like maybe 69 to -- not even, probably like 72 to 80 roughly, or something like that. If I'm just roughly looking at it. And so it's not huge, right? The vast majority of plans are falling within a pretty tight range. There are lots of outliers.

And so you can make a case for the fact that the purpose of the measure is to reduce that outlier performance and pull up the bottom. It is wider for Medicaid then it is for commercial. And so I think it comes down to understanding, you know, who are the bottom outliers when you think about the performance gap? Are bottom outliers in this measure plans that have over five, are averaging five visits?

And if so, then maybe it's not a very large performance gap. If it's plans averaging two or three visits, then it probably is. And I'm also saying this in the context of validity, which

is I think about this more in some of the other comments. I'm a little concerned about this well-child/sick-child visit substitution that probably does exist to some reason.

And so I think that matters a lot if one visit or two visit makes your gap. But if it's bigger than that, then I think -- I think I'd probably put this at moderate.

CO-CHAIR QASEEM: Mary, do you want to respond before we get to Mike and Tom? Do you?

DR. BARTON: I think it's an excellent question. And we don't have the data spread that way at this time. I think as we look towards the future, an access measure like this is going to be increasingly replaced by more content driven measures using electronic health record data. And so, this is not probably the measure that we're going to keep in exactly this form in my vision over the next 10 to 15 years.

But your suggestion is one that I think is excellent. And our analytics group can start to look at the data, because we get the data by

number of visits. And so I think that would be a fruitful inquiry.

MEMBER STOTO: Well I think that those are all analysis worth doing. But right now, the question on the table is, is there a gap? And if you look at the evidence on the bottom of page 16, there's a big gap between Medicaid and commercial. There's a big gap between the 10th and the 90th percentile within each group.

And the Medicaid, in particular, is far away from what's optimal. And you know, it's possible, of course, that would diminish if you looked at five or seven visits, or so on. But it seems to me that's quite unlikely, and you know, for the -- the question is, is there a gap based on the measure that's being proposed? And I think that the evidence is pretty clear that there's a number of different gaps there.

CO-CHAIR McINERNY: Yes, I'm still a little confused. Is the reporting, as we're looking at these data, is this for six or more visits?

MS. BYRON: Yes.

CO-CHAIR McINERNY: Oh, okay. But you do also, you could also report how many children had one visit and how many had two, three, four, five or six?

MS. BYRON: Yes.

CO-CHAIR McINERNY: And I suspect that as the number of visits decreases, the gap decreases significantly also?

MS. BYRON: Yes.

CO-CHAIR McINERNY: The lower the bar --

MS. BYRON: Right.

CO-CHAIR McINERNY: Yes, okay. So the six visits is a high -- the highest bar you're using, although, and as Arjun pointed out, the bar could be raised even a little bit higher.

MS. BYRON: Correct.

CO-CHAIR McINERNY: Thank you.

MS. KHAN: We can go ahead and take the vote. Kaitlynn, would you lead us through?

MS. ROBINSON-ECTOR: Sure. So the

voting for Measure 1392 for performance gap is now open.

MS. KHAN: David, I believe we're waiting for your vote.

MEMBER KROL: I sent it again, did it come through?

MS. KHAN: Yes, I got it. Thank you. Can everyone just press their clicker one more time, please? We're supposed to be at 20.

MS. ROBINSON-ECTOR: Okay. Great. Thank you. Everyone's votes are in and voting is now closed.

Nine voted high, 11 voted moderate, zero voted low and zero voted insufficient. So the measure passes on this criterion.

MS. KHAN: So, moving onto scientific acceptability of the measure properties. Let's start with reliability. Does anyone have any questions on reliability? Arjun?

MEMBER VENKATESH: So I was reviewed this, and I thought the reliability of the measure was going to be fairly high, right? It's trying

to measure visits and visits are fairly well captured as it comes -- to what they are within claims. And so I think that was high. And the reliability statistics they reported were quite high, is why I would rate that high.

I would raise one validity concern, which I don't want to sound like a broken record around this idea of potential substitution. I recognize that we don't have data around that now, I guess what I would ask is probably that maybe within this Committee's report, the guidance to the developer be that that be something that is assessed between now and annual update for next year.

Because I think I would interpret this measure very differently if I found out that the total number of visits looked fairly similar between groups, or that performance looked much higher when you accounted for total number of visits.

Recognizing that reimbursement incentives and a variety of other things are going

to have folks potentially doing healthy and sick care at the same time. And that the sick visit may be what we actually measure. And so we may not be validly capturing the measure focus of healthy visits when we only measure well visits.

MEMBER HILL: I would like to support that and add a little explanation in, that we're seeing a strong movement toward the medical home and bundled visits for the convenience of patients. And so that will continue to grow.

CO-CHAIR McINERNY: Comments?

(No response)

CO-CHAIR McINERNY: Ready to vote?

CO-CHAIR QASEEM: Before we vote, also, I was just talking to Elisa as well. So we can actually ask that, if the Committee feels strongly, that this comes back for annual review, that it needs to be revised or something like that, right?

MS. MUNTHALI: I'm sorry, I don't want to have both mics. And I think we'd like to get input from NCQA, if that would be possible? In a

year, during your annual update review or next maintenance review in three years?

DR. BARTON: It's much easier to promise within three years then one. And I think the question is, you know, as we reevaluate all of our measures on a somewhat regular cycle, usually within a three to four years' time, we take it apart in the way that you're asking.

And so, I think that's the question is, how do we ensure that the content of well care is provided? And that is the intention of this measure. I just want to be clear. Something could be billed as a sick visit, but if it has the components in it that are what we're looking for, to add up to a well care content, it gets counted in the six.

So, I think it's really reassessing the face validity of the components that we've listed that are required to be fulfilled over the six visits. And making sure that, you know, our expert committees and our measure development sequence can confirm that that's still the right content

over the first 15 months.

So I appreciate those specific recommendations because that can help guide how we direct our reevaluation process.

MR. VALDEZ: That just raised a question for me. And that is, so someone bills for a sick visit, but then they can report to NCQA that that visit included the components of this well-child and count it towards their well-child counts?

MEMBER HILL: There's a --

MR. VALDEZ: So they could bill one way and report it in another way?

MEMBER HILL: There's a coding modifier.

MR. VALDEZ: Because you have multiple reporting actions.

MEMBER HILL: There's a coding modifier when you have both of those happening. I'm a certified coder. And so when you have both things happening in a visit, you put a modifier on it. You're able to identify that

administratively.

CO-CHAIR QASEEM: So Arjun and Catherine, would you be comfortable if we make a recommen -- a strong recommendation on this measure based on your comments and go with the three year cycle? Or would you like to push for a one year cycle?

MEMBER HILL: I would vote for one year, only because of the speed of innovation I'm seeing with the, you know, accountable care organizations and medical homes and those kinds of things. We're seeing real dynamic shifts.

CO-CHAIR QASEEM: Arjun?

MEMBER VENKATESH: One year.

CO-CHAIR QASEEM: And so --

MS. MUNTHALI: Sorry. And I just wanted to remind the Committee, because it is a Standing Committee, you will have multiple opportunities to engage with NCQA. We can follow the progress of this.

And you know, the reason we asked NCQA is because we wanted to see the feasibility of them

being able to do this. So, we will continue discussions with them. And we will include this as a recommendation in the report.

But we wanted to remind everyone that this measure as specified is what you're voting on. And this is a recommendation for a future duration of the measure.

CO-CHAIR QASEEM: Okay. So what we are going to vote is to approve this measure of course. And with a strong recommendation of revisions in a one year time period.

MS. ROBINSON-ECTOR: So, voting for Measure 1392 for reliability is now open.

Can everyone press it one more time, please? Okay.

Thank you. All the votes are close or all the votes are in. And voting is now closed.

Ten voted high, ten voted moderate, zero voted low and zero voted insufficient. So the measure passes on the criterion of reliability.

MS. KHAN: So we'll move onto validity. Are there any comments on validity of the measure?

(No response)

MS. KHAN: Okay. Kaitlynn?

MS. ROBINSON-ECTOR: Voting is now open for validity for Measure 1392.

All the votes are in. And voting is now closed.

Eleven voted high, nine voted moderate, zero voted low and zero voted insufficient. So the measure passes on the criterion of validity.

MS. KHAN: So we're onto feasibility. Any comments on feasibility?

(No response)

MS. KHAN: Let's go to a vote.

MS. ROBINSON-ECTOR: Voting for feasibility for Measure 1392 is now open.

It looks like all the votes are in. So voting is now closed.

Fifteen voted high, five voted moderate, zero voted low and zero voted insufficient. So the measure passes on the criterion of feasibility.

MS. KHAN: Are there any comments on

use? Usability and use?

(No response)

MS. KHAN: Okay.

MS. ROBINSON-ECTOR: Voting is now open on usability and use for Measure 1392.

MS. KHAN: Can everyone press it one more time please?

MS. ROBINSON-ECTOR: Thank you. All the votes are in. And voting is now closed.

Fifteen voted high, five voted moderate, zero voted low and zero voted insufficient. So the measure passes on the criterion of usability and use.

MS. KHAN: Anyone have any comments before we vote on overall suitability?

(No response)

MS. KHAN: Okay. Kaitlynn?

MS. ROBINSON-ECTOR: Voting for overall suitability and for endorsement for Measure 1392 is now open.

MEMBER ASOMUGHA: One is yes, two is no, right?

MS. KHAN: Yes, one is yes and two is no.

MS. ROBINSON-ECTOR: Okay. All the votes are in. And voting is now closed.

Nineteen voted yes and one voted no. So the measure passes for recommendation for endorsement.

CO-CHAIR McINERNY: Okay. Very good folks. We're pretty much on schedule. Now we can move to measure number three, 1516, well-child visits in the third, fourth, fifth and sixth years of life.

The developer is NCQA. As I understand it, a pass for this is if the patient has made one or more well-child visits in those years. And that would be out of a total of, if I'm correct, four visits. Three, four, five and six.

So, if they make one out of four visits, they get a pass. Is that correct, from the developers?

DR. BARTON: Not exactly. So the denominators are all the children who are in a given

year, either three, four, five or six. And they have to have had one visit in that year.

So, next -- so it's not a question of looking over the four years for only one visit.

CO-CHAIR McINERNY: Oh, okay.

DR. BARTON: It's each year. Looking among that age group for a visit.

CO-CHAIR McINERNY: And that's all children in -- attributed to the practice?

DR. BARTON: Actually to the health plan.

CO-CHAIR McINERNY: Oh, the health plan. Okay.

MEMBER STOTO: But is it of the ones who had a visit in that year? Is that what you said?

DR. BARTON: Of the children whose birthdays make it such that they are either three, four, five or six years of age, across the health plan, did they have at least one visit in that year?

MEMBER STOTO: Okay. Thank you. I misunderstood.

DR. CHIANG: So Mary, is it any visit?

Or a well-child care visit?

MS. BYRON: Well-child.

DR. CHIANG: Well-child care?

MS. BYRON: Well-child visit. Same as the previous measure.

MEMBER BIALEK: This might not be the right time to ask this question, but I didn't want to ask it specific to the other measure or really this measure. It's a general question that maybe at some point we can discuss if this is not the appropriate time.

But it really -- the question is around usability where we are supposed to take into consideration potential unintended consequences I think.

And I'm just wondering on the cost side, in terms of the implications to the organizations who provide care for the uninsured, like federal quality provided health centers, state health departments, local health departments, others. That by establishing a measure, you know, like 15, eight visits, six visits, whatever it may be, has

a cost implication and something else might give later on.

And so, there's that issue. And developers often don't address the cost implications or the gaps that might exist for the uninsured in this instance.

And I'm just -- I didn't know if that was appropriate for consideration or if that is something that maybe developers could be asked to address, is the potential implication for the institutions providing care for the uninsured.

But often we're focused on Medicaid, Medicare, you know, private insurance, et cetera. And like I said, if it's not the appropriate time, that's okay. I just wanted -- didn't know when to ask the question.

MS. MUNTHALI: No, that's a very good point you bring up. Although we're talking about evidence, but we are talking about the measure in general.

Some of the issues that came up in the measure we just talked about, probably are the

same. This is something new that's been raised. And I don't know if you want to pose that question to NCQA.

We of course are capturing all of the discussion while usability and use is not a must pass, it is part of our criterion. And we are considering that and you should be too as you're voting.

CO-CHAIR QASEEM: Mary, would you like to respond? Because I think it's an important question also.

DR. BARTON: Yes. I think it is an important question. And I do want to reassure the Committee that when we do develop a measure and we go through our process of working with multiple stakeholders, we post it for public comment.

You know, those issues do come up. So stakeholders raise them. And when they are evaluating measures, say in the HEDIS measure set, we often do hear them talk about well, is this measure, you know, is the juice worth the squeeze when you compare it across a whole set of measures

that we have in HEDIS.

So, it is very relevant. And it is something that we do consider. For a measure to even get into HEDIS, they often do consider it against all the other measures that are in HEDIS that health plans are reporting.

And we have to answer that question of, is it important enough to be adding. And you know, where should we be taking away.

So, our committee on performance measurement, which looks at all measures used in NCQA programs, evaluates measures as a whole set, not just as an individual measure. So, I'm glad you raised that.

CO-CHAIR QASEEM: So the summary of your response is that based after looking at the cost, you think that this measure is a good measure still?

DR. BARTON: Yes.

CO-CHAIR QASEEM: So, Ron, do you think there's a need to add any exclusions? Will that help to -- in any way?

Under exclusions right now, there's no exclusions listed. Will that help in any way? Or do you think not?

MEMBER BIALEK: No, I don't know if there's a need to add to the exclusions. It's just I'm wondering when guidance is provided to measure developers and they're filling out the form that often the evidence that's presented is for those who have insurance. Not for institutions providing care for the uninsured and the implication that might have.

That's -- I'm suggesting that maybe staff when they have those discussions could ask for that issue to be addressed to some degree. Because we still have a substantial number of uninsured in the country and institutions providing care.

MS. KHAN: So, before we continue to talk about exclusions, let's just go back to evidence very quickly. Are there any comments on the evidence of the measure focus before we take a vote?

MEMBER STOTO: My only comment is the same one I made on the previous measure. That it measures visits not the content of the visit.

MEMBER SPANGLER: I had a question about the evidence. I don't -- I know that it was from the AAP and Bright Futures that recommends at least four visits in those four years.

So my question is, based on your measure, if the patient had four visits when they were three -- or sorry, two visits when they were three and two visits when they were five, they would follow the recommended guidelines, but miss on this measure, correct?

DR. BARTON: It would succeed in two of the four years and fail in two of the four years.

MEMBER SPANGLER: Even though they would be following the recommended guidelines?

DR. BARTON: If it is as you say.

MEMBER SPANGLER: That's what it says in the application. So, okay.

CO-CHAIR QASEEM: Catherine? You had a question?

MEMBER HILL: That was my same question. The way the measure is written and you have the four years and it's an annual measure. You have a four-year recommendation, you know, that's an annual measure. That was --

MEMBER SPANGLER: So a measure that would follow the guidelines would be a measure where they've had four visits, at least four visits over the four-year period. Not one visit per year at least. Okay.

CO-CHAIR McINERNY: I think that's important because, you know, life being life, the patient may come in at three years one month of age and then three years 11 months of age, the first for the three-year visit, the second for the four-year visit. But that's two visits within one year.

CO-CHAIR QASEEM: Eric?

MEMBER FRANCE: Well, just to clarify, I think the measure says that if you are -- if you turn four years of age in 2015, did you have a well-child visit in 2015, yes or no?

So, you're in the numerator of yes. And then it asks that of the six year old. So it's looking at the cohort who are ages three to six. And for each individual, they're looking at that year and whether they had a well-child visit in order to be in the numerator.

I think my issue with the metric is I don't think the evidence is there to say, you know, the six year well visit is an important visit to have. Especially if you've had it at age five as well.1407

You know, the struggle is, okay, well look at each of these individually, age three, age four, age five, age six, and ask each one individually is the three year well visit an important visit and why? Is the four year? Is the five year? Is the six year important?

And in particular, if you just had a five year well-child visit, do you need a six year well-child visit? Now that you're probably in school and environmental screenings are happening

at school and so on.

So, it's the breadth and the broadness of this measure that loses some of the specificity that I don't think the evidence is there to suggest that, you know, yes, that six year visit for a well visit is an evidence based valuable visit.

CO-CHAIR QASEEM: And just for follow up point, this is an expert based opinion. I mean, this is not an evidence base -- well, depending on how you define evidence, I mean, you can keep it in mind.

Right? If I remember correctly, it's an expert based.

Mary, you have a comment?

DR. BARTON: Well, I just wanted to point out that one of the things that has to be taken into account is the population. And you know, when you're looking at zero to 15 months kind of measure, you can figure that most people who give birth are not looking to switch insurance immediately.

And so, that you have a stable population and you can require that they be members

of the health plan for that 15 months. When you're talking about four years of life, through this time, it really restricts your population severely if you require continuous enrollment for four years.

And Jason, this is what would be required to create a measure that counted exactly to the guideline. You would need to find people who are only there for four years of continuous enrollment. And find out if they had four visits over those four years.

And the Medicaid plans told us that they did not -- they were not interested on balance, you know, going to that restrictive denominator. They would rather see what was happening for access for the kids in those years of life.

So, it's a -- again, it's a place where sometimes a measure has to take a small turn away from a guideline in order to be practical and feasible.

MEMBER SPANGLER: So you're saying, if they have four different plans, they had one at age

three, age four, age five, age six, for some reason they were switching plans, they would still, if they had a visit, they would still meet the measure each time?

DR. BARTON: Yes.

MEMBER HILL: So there we're trying to come to terms with the churn rate in -- and I don't know that we all have a strong sense of what the churn rate is. Because that effects the validity of the measure, right? On the coverage.

CO-CHAIR QASEEM: So I asked NQF staff actually to dig something up for me. And maybe you all heard now.

If it's an expert based opinion, isn't that automatically low? And I missed the initial first two measures. Again, apologies for being late.

I was not really sure for -- and it's voted, so let's move on at this point. But even for this one, we need to keep it in mind it's an expert opinion.

Isn't that automatically going to be

low?

MS. MUNTHALI: So, we pulled up the algorithm for everyone on the phone. And what we walked in, I don't think we see everything on the screen. If you go down.

So, of course it's not an outcome measure. This is a process measure. And so, I need to look through this.

CO-CHAIR QASEEM: Sure, sorry.

MS. MUNTHALI: And it says for measures that assess performance in an intermediate clinical outcome process or structure, we actually went through this box before when we did the first measure. And what we said was no.

And is there empirical evidence in purple, right there, number seven, without systematic review or grading of the evidence? There is empirical evidence that they've brought forward. And so it's yes.

CO-CHAIR QASEEM: Okay.

MS. MUNTHALI: Does the empirical evidence that is summarized include a study of --

studies in the body of evidence? And everyone is agreeing yes. I'm looking at the people that reviewed. So we move on to number nine.

And so then this is where the Committee can either decide if you agree that the submitted evidence has high certainty, that the benefits clearly outweigh undesirable effects. And this is where you have the option of, this is how Arjun came to the moderate decision.

Arjun, am I following your decision points correctly? If you had said no at any of those points from eight, it would have received a low rating.

MEMBER VENKATESH: Yes, I think that follows the general logic before. I guess the question I would ask, I don't know this measure as well as the past one. Is that, in the previous one, you had expert consensus and guideline.

But there was some empirical evidence. Meaning, that the empirical evidence was with respect to, you know, developmental activities, healthy, screening, things like that.

And we raised the question of, okay, maybe measuring the visit doesn't measure that. But there is empirical evidence that doing, you know, a variety of health related things and during the 15 months was related outcomes.

I don't know this evidence in this age group, if it's the same. Is there some like that? Some empirical evidence?

Obviously not randomized, but something that suggests that on balance, allows us to do basically the bottom of that purple box, right? That there's some high amount or some type of evidence that indicates that it would be a net benefit?

I don't know about that for this age group.

MS. BYRON: So it is similar, you know, where we -- as we talked about earlier, we're not going to see a randomized trial that says, you know, number of visits here versus number of visits there.

But, the contents is slightly different

for these age groups. So you look -- actually in the new information that we provided, we did talk through some of the content things, such as vision screenings that happen in order kids versus infants.

And making sure that they get also the anticipatory guidance. You know, doing a physical examination. Blood pressure screening, those sorts of things.

So, the content changes slightly. But the evidence is about the same as the earlier measure.

CO-CHAIR QASEEM: Arjun, what do you think? And again, I don't want to be a guideline snob, but I was at the grade meeting and this answered me all that.

I don't want to get into the details. And Mary, you know where I'm coming from when it comes to this kind of stuff.

But I'm not sure if all the evidence at least when I reviewed this measure, and I wasn't part of this group, was presented. But Arjun, what

do you think since you were there?

MEMBER VENKATESH: I think it's hard. And it's hard because you're trying to interpret evidence in the context of two things.

One is what are you actually measuring? And that question that we always ask within that, which is, then is there a linkage between the process being measured and the undesired outcomes?

And I think I felt more comfortable with it for the prior measure because people told me the story. And articulated the story of okay, you know that vaccinations and there's these certain types of clear explanatory guidance that happened within those visits in the zero to 15-month period.

Where it became easy for me to make a linkage between well-child visits, some type of health outcomes. And okay, we're measuring well-child visits. Okay, there's evidence base, I can get myself to moderate in that box.

This one's a little trickier and I think there's a place that's -- and tell me, like is the best place to look at this, what we call kind

of 1A6 now? Which is kind of the other evidence section of the worksheet.

Plus kind of what NCQA sent out earlier? Because I think in that context, a lot of it is, from what I understand, what's shown is mostly consensus. Right?

So it's not like saying okay, hey we did an observational study that had 1,000 kids that had various well-child visits. And those that had more visits were more likely to get blood pressure screening. And therefore had some healthy outcome of something like that.

And so I think for me, I think I'm probably, if I can't get into that purple box, where I'm at is actually the red box, which if you scroll down is one below.

MS. MUNTHALI: The evidence exception.

MEMBER VENKATESH: And so, really to me where I met and thinking about this is, does it meet 12? Right?

So if you think it doesn't have really any empirical evidence and it's really just based

on expert consensus, and so, then you have to get yourself past 12 which asks, does it agree that it's okay or beneficial to hold providers accountable for performance in the absence of evidence?

And so, you know, consider the potential detriment to endorsing the measure versus taking the focus away from doing the measure and things like that. And so, I think that's probably where I would rate it.

I think it would be -- I cannot -- I can't think of unintended consequences that would be bad. The only thing I could even think of are like Ron mentioned, was kind of the cost part of this and then thought about that.

And so, to me, it fits that box more so then the purple box.

CO-CHAIR QASEEM: So others in this group's approval?

MEMBER LUCK: And what's the distinction you see in this measure versus the previous one? Is it just immunizations?

MEMBER VENKATESH: I think it's

immunizations and there was a couple of other studies that they had kind of cited that were not expert consensus about, you know, just some original research in the space. Versus -- I don't think this had as many, but you know, correct me if I'm wrong, it's not my space of expertise.

CO-CHAIR QASEEM: Go ahead.

MEMBER SALIVE: Well there are immunizations given commonly in age four to six and seven that you know, and every year the flu shot. So I mean, I think there's plenty of things there.

I think, you know, they combined a bunch of things. But there are plenty of other preventative services in this age group that are recommended that there are like a few, I mean, several, three, four, something like that.

So, the visits have those potential. I mean, I don't think, you know, we are recognizing that not every visit will involve that.

And I also wanted to make a comment on this notion of the uninsured. I did look up the statistics and their churn. And I think that most

people -- most children are covered by their parent's insurance or Medicaid.

So it's related to that. And the uninsured rate of all children is, according to the latest stats I found is only eight percent.

So I think that, you know, and no one is checking -- they're not in the denominator at this rate. So I don't think that's an issue that we should concern ourselves with.

So I am much more positive on this measure then what I'm hearing from other people.

CO-CHAIR QASEEM: So if there are no other comments, I think -- oh, go ahead.

MEMBER FRANCE: Well, I note that I have a hard time thinking about the evidence without thinking about its usability for some reason right at the end of it. Because as is mentioned, I think in a document, health plans are using this, or are being measured by it.

And rankings listed in consumer reports on the performance of your health plans are based in part by this measure. So, some health plans

will therefore say geez, you know, we've got to be high ranked.

We've got to chase after this. We have to be sure every kid comes in every year from ages three to six.

And that always feels fine when it's a strong evidence base behind that measure to pursue it with that kind of -- that use. So, there's an aspect of a commitment to its use when one begins to say it's an endorsed measure.

So, I -- it's almost a face validity question. Can I get up in front of a bunch of pediatricians and say, we absolutely need to bring everybody in every year between ages three, four, five and six.

Now, I know you saw them last year and the year before and everything's fine. But there's a strong evidence base that says you've got to come in at age six as well for another well-child visit.

That's where the face validity of making that argument becomes difficult in light of

the quality of the evidence that currently exists in support of a six year old well visit. Which is part of this metric.

CO-CHAIR QASEEM: And that's where I think that you show off just because it's a good clinical practice doesn't mean that you have to make it a measure. Eric, right? I mean, I think no one is going to disagree.

But the issue is that we don't know if there is evidence for it. At least to better outcomes. Although it's a good clinical practice.

Anyone else? Because this is an important issue. The reason I think it's an important issue is going to impact approval or the bottom line of the measure.

It's like -- so I'd like to hear from some other folks as well. Go ahead.

MEMBER CARRILLO: I guess I'm wondering, in terms of the professional societies that have advocated this measure in the past and sort of foundational, do we have recent evidence in terms of review of the characterizations of the

measure? The support of the components of the measure from professional societies that have stood behind it?

That pediatric societies, public health societies? Professional groups?

MS. BYRON: Are you asking about the feedback we've received from different societies and that sort of thing?

MEMBER CARRILLO: Yes. And their feelings on the subject.

MS. BYRON: Well, you know, we hear -- this is a health plan level measure, so we hear a lot actually from states, in particular Medicaid, noting the importance of this measure.

I don't -- so in terms of the evidence, you know, I would say it's the same, it's very similar for this measure and the first measure. I mean, the different things are vision screening, vaccinations. You do a flu shot. The anticipatory guidance.

Those are the content pieces that we look at in this measure that are supported. We

hear from states saying that this measure in addition to the measure before it are very important for them to be able to assess access.

I believe, you know, the way they look at it, is they look at this measure in addition to some of the measures that we have for content such as immunizations and look at them as a whole picture to be able to provide information on whether or not they feel their populations are getting needed services.

We do have professional societies that sit on our measurement advisory panels. And clinicians tend to be in favor of this measure as well.

I think they look at it as a basic opportunity to be establishing relationships with patients. To be talking through some of the developmental issues through childhood, anticipatory guidance, schools and coping, and some of those things that all kind of contribute to raising a healthy child.

I don't know if that answers your

question.

MEMBER CARRILLO: Well, yes. I mean, and the fact that it's a proxy measure for access is very important. And that access represents things to see a child that has been having abuse at home. Or a child that's disheveled.

You know, there are other very important significant yet less tangible observations that go along with the frequency of access. But I think that there is value inherent in a proxy access measure.

CO-CHAIR QASEEM: So Mike and Arjun and then we'll vote.

MEMBER STOTO: Yes, I'm all in favor of evidence too. But I'm trying to think, what evidence could someone produce for this?

I mean, clearly you're not going to do an RCT. And even if you tried to do an observational study, it would be quite difficult to compare the kids who get these visits without, you know, and adjust for other confounders and so on.

So and maybe this does put us in the insufficient with exception box as Arjun was suggesting. But I don't think that's where we have to be.

CO-CHAIR QASEEM: Arjun?

MEMBER VENKATESH: Yes. As I think about it more, I mean, I think the access component of this is the primary driver for the use of the measure. And it's a huge benefit of the measure in terms of -- but it's something that when we think of how we interpret the evidence and we put into this chart, we're not thinking about it with respect to that, right?

Nobody's studying whether or not this is a meaningful measure of access. To some degree that requires your face validity to say that this is a measure of access.

And if it is, that is a huge potential benefit to the measure. And so, being in the rate as insufficient with evidence with exception box, still allows the measure to proceed and get full endorsement.

I think it probably actually, the more I think about it, it totally fits in there. Because you've got this tremendous benefit on the access side.

And it's, you know, honest about the fact that in terms of clinical evidence, we're just not there yet and it either hasn't or maybe it won't be studied. But, it allows the measure to still be endorsed.

CO-CHAIR QASEEM: Good point. Last comment. Catherine?

MEMBER HILL: And I think for me the big hesitation is around the fact that we grouped three, four, five and six year olds together when what we educate and have on our CDC website about immunization has a different categorization. It instead recommends ages four to six.

And so the -- I think the way it's cohorted makes it even harder when you put that age three in there. And then everything else you got posted on recommendations has an age category of age two to three. And then it has an age category

of four, five and six.

Then it's a little harder -- you feel like your disadvantaging, you know.

CO-CHAIR QASEEM: Okay. Let's vote.

MS. ROBINSON-ECTOR: Voting for evidence for Measure 1516 is open. And for those on the phone, I'm just going to read off the options.

So one is high. Two is moderate. Three is low. Four is insufficient evidence. And five is insufficient evidence with exception.

MEMBER ASOMUGHA: Can you repeat the last three one more time?

MS. ROBINSON-ECTOR: Sure. Three is low. Four is insufficient evidence. And five is insufficient evidence with exception.

MEMBER ASOMUGHA: Okay.

MS. ROBINSON-ECTOR: Okay, it looks like we're -- oh, okay, so. All the votes are in.

One voted high, two voted moderate, three voted low -- oh, so. I'm reading the wrong thing. One voted high, four voted moderate, five

voted low, one voted insufficient, and one voted eight. Thank you, yes. And eight voted insufficient evidence with exception.

MS. KHAN: So, the measure will pass. We have enough votes for it to pass. It will be consensus not reached.

CO-CHAIR QASEEM: Can you just tell us whether or not it would pass? As I can't find, I can't remember, I'm sorry.

MS. KHAN: How does it pass?

CO-CHAIR QASEEM: Yes. So what's special, but you --

MS. KHAN: Oh, 60 percent approval is when the measure is approved. Anything between 40 and 60 is consensus not reached.

This evidence exception puts the measure in the approval category. So that's why it's the eight, plus the four, plus the one.

CO-CHAIR QASEEM: Oh, thanks.

MS. KHAN: Yes.

CO-CHAIR McINERNY: Gap. Any discussion on gap?

(No response)

MS. ROBINSON-ECTOR: So, voting is now open for Measure 15 --

MS. KHAN: Oh wait, I'm sorry. Robyn did just the calculation. So we hit 56 percent approval actually. So it is consensus not reached for evidence.

The measure -- we're still going to go forward with the rest of the votes and we'll revisit the evidence criteria after public and member comment.

CO-CHAIR QASEEM: It's 13 out of 19, right?

DR. NISHIMI: It actually -- the 40/60 threshold applies to the full Committee. Not just those who are here. So the --

MS. KHAN: No, it's those who are here.

DR. NISHIMI: Oh, you told me it was --

MS. KHAN: No, quorum is for who's here.

DR. NISHIMI: Oh, okay. Then never mind.

MS. KHAN: Yes.

DR. NISHIMI: It's okay. I misunderstood. I thought it was over -- 10 over 23.

MS. KHAN: Can you take the votes --

MEMBER MOLINE: So did it pass or do they confirm?

MS. KHAN: It is passed.

DR. NISHIMI: It passed.

MS. KHAN: Yes.

MS. ROBINSON-ECTOR: Okay. I'm just going to read the votes for evidence one more time.

So, one voted high, four voted moderate, five voted low, one voted insufficient evidence and eight voted insufficient evidence with exception. So it passes.

Okay. Voting is now open for performance gap. And for those on the line, one is high. Two is moderate. Three is low. And four is insufficient.

CO-CHAIR QASEEM: What is the N supposed to be here?

MS. KHAN: It's supposed to be 19. Sorry about that. The voting is now open. And for those on the call.

MEMBER ASOMUGHA: So wait, are we still on gap? Or --

MS. ROBINSON-ECTOR: Yes. We're still on performance gaps.

MEMBER ASOMUGHA: Okay. Do you need me to resend my vote?

MS. KHAN: No, I have it.

MEMBER ASOMUGHA: Okay. All right, thank you.

MS. MUNTHALI: So we also wanted -- the N is 19. Michael is not voting on the phone. So, we just wanted to clarify that for you.

CO-CHAIR QASEEM: But now it's 23.

MS. MUNTHALI: That's wrong. So what we may have to do is do a hand vote or something until we fix the problem.

MEMBER BAER: Well, just to let you know, Mike is back on the phone.

MS. MUNTHALI: Thanks Mike. So now

it's 20.

MEMBER BAER: Okay.

MS. ROBINSON-ECTOR: We need to do a hand vote though.

MS. MUNTHALI: Okay. Sorry.

MS. ROBINSON-ECTOR: So, for everyone who votes high, could you please raise your hand? Okay, thank you.

Okay. And for everyone who would like to vote moderate, if you could please raise your hand?

For everyone who wishes to vote low, if you could please raise your hand? Okay.

And for everyone who would like to vote insufficient, if you could please raise your hand? Okay.

So the vote is high ten, moderate ten, low zero and insufficient zero.

MS. KHAN: So at this time, we're going to start voting on scientific acceptability. Are there any comments on the reliability of the measure? Or what was provided by the developer?

(No response)

MS. ROBINSON-ECTOR: For reliability for Measure 1516, voting is now open. And for those on the call, option one is high. Option two is moderate. Option three is low. And option four is insufficient.

Oh, hi Michael, we're still waiting for your vote.

MEMBER BAER: Moderate please. I'm going to go to my other computer because this one's not working. I apologize, so, that's why I did not respond.

So, I will respond via phone and I'll be back on the computer as soon as I can.

MS. ROBINSON-ECTOR: Great. Thank you. Okay, all the votes are in. And voting is now closed.

For reliability, ten voted high, eight voted moderate, zero voted low and two voted insufficient. So the measure passes on the criterion of reliability.

CO-CHAIR QASEEM: Validity, any

comments?

(No response)

MS. ROBINSON-ECTOR: Okay. Voting is now open for validity for Measure 1516. And for those on the call, option one is high. Option two is moderate. Option three is low. And option four is insufficient.

MEMBER BAER: My vote's two.

MS. ROBINSON-ECTOR: Okay. Thank you. All the votes are in, and voting is now closed.

For validity, eight voted high, nine voted moderate, three voted low and zero voted insufficient. So the measure passes for the criterion of validity.

MS. KHAN: So now we're on feasibility. Are there any comments from the Committee on feasibility?

(No response)

MS. KHAN: Okay. Kaitlynn?

MS. ROBINSON-ECTOR: Okay. Voting is now open for Measure 1516 for feasibility. And for

those on the phone, option one is high. Option two is moderate. Option three is low. And option four is insufficient.

MEMBER BAER: Mike on the phone votes one.

MS. ROBINSON-ECTOR: Okay. Thank you. All the votes are in, and voting is now closed.

17 voted high, three voted moderate, zero voted low and zero voted insufficient. So the measure passes for the criterion on feasibility.

MS. KHAN: So now we're on usability and use. Are there any comments from the Committee on usability and use?

(No response)

MS. KHAN: Okay. Kaitlynn?

MS. ROBINSON-ECTOR: Voting for usability and use for Measure 1516 is open. And for those on the call, option one is high. Option two is moderate. Option three is low. And option four is insufficient information.

MEMBER BAER: Two from Mike on the

phone.

MS. ROBINSON-ECTOR: Okay. All the votes are in, and voting is now closed.

11 voted high, seven voted moderate, two voted low and zero voted insufficient. So the measure passes for the criterion of usability and use.

MS. KHAN: Are there any comments before we take a vote on overall suitability for endorsement? Okay.

MEMBER HILL: My question is, based on our answers to the previous questions, can't you forecast this? Is your logic sufficient to -- once you've, you know, voted on all the independent measures, wouldn't that to some degree forecast whether it was going to pass or not?

MS. KHAN: Not always.

MEMBER HILL: Okay.

MS. KHAN: A lot of times, yes.

MEMBER HILL: And so which of the components are must pass components?

MS. KHAN: Importance to measure and

report. So evidence and performance gap as well as scientific acceptability. So your reliability and the validity.

MEMBER HILL: Okay. Thanks.

CO-CHAIR QASEEM: One of the core?

MS. KHAN: It is.

CO-CHAIR QASEEM: It is.

MS. KHAN: Part of importance to measure the report.

CO-CHAIR QASEEM: Oh, okay.

MS. KHAN: Okay.

MS. ROBINSON-ECTOR: Voting is open for overall suitability for endorsement for Measure 1516, well-child visits in the third, fourth, fifth and sixth years of life. For those on the call, option one is yes and option two is no.

MEMBER BAER: Mike on the phone, one.

MS. ROBINSON-ECTOR: Okay. All the votes are in. And voting is now closed.

16 voted yes and four voted no. So the measure passes for recommendation for endorsement.

MS. KHAN: Okay. Thank you everyone. We're going to have public and member comment at this time.

Operator, are there -- can you open the line please for public and member comment?

OPERATOR: At this time if you would like to make a public comment, please press star then the number one on your telephone keypad.

And there are no public comments at this time.

MS. KHAN: Okay. So, in lieu of not having any public comments, let's take a break until

CO-CHAIR MCINERNY: Wait, Renee has something.

MS. KHAN: Oh.

MEMBER FRAZIER: I just wanted to say, I'm just so glad the Committee passed this. One of the things that in my work with patient/provider engagement, having something to focus on to keep them engaged in preventative and primary care --- or parents, beginning at age one through this

measure, which was age six -- is not insignificant. It's a helpful measure.

We actually had this debate in our community. And the pediatricians feel they get zinged a little bit because we've not done a good job of encouraging the mothers and the fathers the importance of engaging their children early on in preventative and primary care.

So I think this Committee made a good decision. I just want to make that comment.

MS. KHAN: Thank you Renee. So why don't we take a break for about --

CO-CHAIR McINERNY: We have three minutes.

(Laughter)

MS. KHAN: We can come back at 10:40.

CO-CHAIR McINERNY: Ten minutes.

MEMBER BAER: What's the next measure?

MS. KHAN: the next measure is going to be 1385, Developmental Screening Using a Parent Completed Screening Tool.

(Whereupon, the above-entitled matter

went off the record at 10:23 a.m. and resumed at 10:37 a.m.)

MS. MUNTHALI: Okay, so before we get started with our next review I'm going to turn it over to Marcia Wilson, who is going to introduce Ron Inge and go through the disclosure of interest.

DR. WILSON: Hi, Dr. Inge. This is Marcia Wilson, and we're doing oral disclosures of interest as committee members have been joining us. Could you please provide us with your name, who you're with, and if you have any paid or unpaid activities to disclosure?

MEMBER INGE: Ronald Inge. I'm with Western Dental Services, Inc., in California. And no, I do not have anything to disclose.

DR. WILSON: Thank you very much.

MS. KHAN: So the next measure we're going to be looking at is 1385, Developmental Screening Using a Parent Completed Screening Tool. And we have our developers, the Child and Adolescent Health Measurement Initiative, on the phone.

Could you guys please introduce yourselves and then go into introducing the measure, please?

DR. BETHELL: Absolutely. Hi, this is Christina Bethell. I direct the Child and Adolescent Health Measurement Initiative, which is based out of Johns Hopkins School of Public Health.

MS. MURPHY: And my name is Caitlin Murphy; I am a research associate here at CAHMI.

MS. KHAN: Did you want to just tell us a little bit about the measure.

DR. BETHELL: Oh, absolutely. No, I wasn't sure if you were ready for me to do that.

Good morning, everyone. So this is the name of this measure might be a little confusing so I just want to clarify that this is a screening tool for screening. This is not actually a developmental screening tool; it's a measure of whether developmental screening, as recommended, occurs. And so that's really something to clarify right up front.

So a little bit of history of this

measure. In 1998 to 2001 we worked on, at the CAHMI on developing a suite of measures of the content of well child care as reflected in Bright Futures with a large initiative that took place with testing, and that's the Promoting Healthy Development Survey which is actually another NQF set of measures, surveying set of measures.

And what was missing from that was a measure of whether developmental screening had taken place. And the reason that it was missing was that it hadn't yet been endorsed or recommended formally by the American Academy of Pediatrics. However, when the statement came out in 2005-6 to recommend developmental screening in pediatric practices and in well-visits, we were then charged to develop a quality indicator of whether that had occurred.

The recommendation for the AAP is, the main feature of it is that it recommends parent-completed developmental screening tools. And this is a measure of whether a parent-completed screening tool was given. And The Commonwealth

Fund, which had supported also the Promoting Healthy Development Survey, supported us to very, on a very fast track develop this measure because it was also to be included in the National Survey of Children's Health for 2007 and '08 to especially get a baseline of what is going on in developmental screening across the country and in states.

Obviously, if we hadn't been successful with the measure and convincing the powers that be throughout all those processes that it was valid, we would not have gotten it into the National Survey. But we were able to do that, and took 2005-6 developing the measure which is summarized in a more detailed technical manual and also in your materials to the degree that space allowed.

So the measure now has been included in the -- it's three items basically. It's age-specific first, and younger kids and a little older at page 5, asking about whether developmental screening occurred. And the wording is very, obviously, is very, very carefully crafted with an expert advisory group and also at this point

hundreds of cognitive interviews. Because every time it's used in the National Survey or in our other work that we'll summarize, it has to go through a whole other process; right? Everyone has to be convinced anew that it means what it says it means to the parents that are being asked about it as one key part of validity, of course.

And so now it's been used in the 2007-8 National Survey of Children's Health, the 2011-12 National Survey of Children's Health, which is national- and state-level data. And then it will be used again in the redesigned National Survey of Children's Health which is in pre-test right now.

It's also included in a set of patient engagement tools that we've worked with the AAP on called the Well-Visit Planner. So parents go and plan for their well-visits. And as part of that, this measure is in there which tells pediatricians whether or not a screen has occurred and queues them up to be able to provide the screening. And the testing for that tool definitely continues to show large increases in developmental screening by

having that information at the time of the visit.

And it's used variously in a lot of research projects. Many people use the Promoting Healthy Development Survey in their, in their research if they're looking at well-visits. And this measure is now a part of that as well as separate.

And, you know, we have the Data Resource Center for Child and Adolescent Health where people query data all the time and ask us a lot of questions and they get information from us. And this is one of the most popular measures, items that we get queries on, that people download information about. If we were to follow up on all of them it would be difficult. But there have certainly been a number of peer-reviewed papers that have used the data nationally and in states based on this measure.

Other applications are Medicaid agencies during the CHIP Demonstration Project in particular. We're looking at the PQMP measures, look at this measure using electronic data with all

of the core caveats and issues around that. You know, there's no perfect data set.

But then in the meantime if they want to look at the state to kind of help understand what was going on, where the risk groups were, where the gaps in screening were using this measure as a population-based measure it could to help direct some of the efforts to improve and even track that improvement over time.

So my last point would really be that since we do have data between 2007 and '11, and the policy statement from AAP came out recommending screening, we did in fact see increases in the states that have really invested a great deal in promoting developmental screening. And several of the other papers that are in peer review are analogous to a validity assessment in the sense that if the measure was valid we would expect certain things to appear, convergent/divergent validity, and in all cases we have.

So I think to say more would get into a much more detailed presentation. But I will

leave it, leave that history with you and then allow you to have questions. If you would like more I can speak more.

MS. MUNTHALI: Thank you, Christina. It looks like Mike has a question or comment.

MEMBER STOTO: This measure I think is very different from a lot that we've looked at, so it's hard to understand. But I want to make sure that I really understand what's being proposed. And actually seeing this level of analysis here makes me think that maybe I hadn't been thinking about it the right way.

I mean I could see how this would be very useful for the kind of research studies that you just mentioned on the phone. It's hard to see how a health plan would use it or a hospital or something like that. Because aren't we just asking the parents have you gotten, have you completed one of these tools without giving them any, knowing anything about the quality of the tool or whether it made a difference in the care for the kids or anything like that?

DR. BETHELL: Yes, well, I mean I think that there's guidelines around screening and that recommend tools that have, yes, obviously been scoured and met criteria to be in the policy statement and recommendation. And what we know is that it often doesn't happen. And that, you know, this is a measure that both documents whether what is recommended in terms of a standard of care is occurring.

It also happens to inform parents by virtue of completing it that it's important. And that in and of itself and the well-visit planner tool, for example, has promoted increases in screening because they don't even know that they're supposed to be, their child is supposed to be having a screening.

So it's definitely used as a quality indicator. And so to the extent that quality indicators are important to practices and health plans and Medicaid agencies, this is a measure they would be interested in. And we have, it's being used in a lot of those settings now, so --

MEMBER STOTO: Can I just maybe follow up on that? Who used it? Do Medicaid agencies actually use this to see whether or not kids are getting the screening? Is that what you have in mind as something --

DR. BETHELL: Well, it depends on, I mean they can first of all because the data is there already, constructed for them at the state level in the National Survey, and sampled as such. So what I know is that I'm in the room with some Medicaid direct -- medical directors or Medicaid directors, and they're referring to the data and using it to inform their decisions about quality improvement, about how things are going in the state.

And then when you get down to the clinical level the measures might change because there's another developmental screening measure that we also worked on in your tool kit, which is based on electronic records. And that has its own limitations. They both do.

And this one is more getting at

population-based, community-based because screening often occurs outside of the clinic. And you're not going to get that information through the electronic record, and oftentimes it's not recorded in the electronic record, and there's under-counting of parents who are getting the screening.

So it's complementary. It preceded, actually, the other measure.

So Medicaid agencies that I know of, you know, access the data. Title V agencies are held accountable to this measure and will be going forward through the new Title V block grant as well. So I think it's recognized as a valuable measure for purposes of performance measurement and improvement.

CO-CHAIR QASEEM: So Ron?

MEMBER BIALEK: Yes, I think the subject area of developmental screening I think is a real important one, something that is really useful to do. I am trying to understand though a little bit more about the measure, what's being

asked.

So dental visits is in the denominator I noticed. And so if -- it didn't seem like there was a standardized tool for parents to use, at least the way I read the measure. So my first question is: Is there a specific tool that is supposed to be used?

DR. BETHELL: Yes. So when I -- yes, let me summarize. I don't know what you meant about dental visits. That's not really -- we have another measure on dental but this has nothing to do with dental visits. I mean there is a dental screening, dental visit measure. So I'm not sure if you're looking at that.

MEMBER BIALEK: No.

DR. BETHELL: But let me just --

MEMBER BIALEK: In this particular one in the denominator it had dental visits as part of the denominator. I'm just wondering what the tool is. So the developmental screening that the parent conducts you specify as a screening tool to be used. There's some discussion of a screening

tool that seemed like it was validated by 23 or used by 23 people.

I wasn't sure if, if --

DR. BETHELL: No.

MEMBER BIALEK: -- one checks the box as "yes" --

DR. BETHELL: Right. Okay, okay, so let me see if I can unpack that for you a little bit.

MEMBER BIALEK: Thank you.

DR. BETHELL: So the recommendation, so the AAP's policy statement and recommendation for screening for young children is, came out a number of years ago, and the primary recommendation is to screen children for developmental problems using parent-completed screening tools that are included and recommended for that purpose.

This is a measure --

MEMBER BIALEK: I'm sorry, recommended by whom?

DR. BETHELL: The American Academy of Pediatrics --

MEMBER BIALEK: Okay.

DR. BETHELL: -- and their large body of community. And also developmental screening is of course a core measure for CHIPRA and for Title V and it's recognized as a very import -- that developmental screening occur is a measure. That's --

MEMBER BIALEK: So they, I'm sorry, they're recommending a specific tool or different tools? I hear that they're recommending screening, but are they recommending specific tools?

DR. BETHELL: Yes, exactly. They do recommend specific tools, a whole fleet of them. And the strongest recommendation is using parent completed screening tools. And this measure was anchored to that recommendation.

CO-CHAIR McINERNY: So the tools that are recommended most commonly are the Pediatric Evaluation of Developmental Status or the PEDS.

DR. BETHELL: PEDS, right.

CO-CHAIR McINERNY: And then Ages and

Stages questionnaire, ASQ.

DR. BETHELL: Right. Yes, and this --

CO-CHAIR McINERNY: Now there are some other ones, but those two probably --

DR. BETHELL: Yes.

CO-CHAIR McINERNY: -- at least 75 percent of the tools that are being used.

DR. BETHELL: Right. And this was very, very specifically measured, developed --

CO-CHAIR McINERNY: Right.

DR. BETHELL: -- for that purpose.

So, so just with the 23 thing that, you know, cognitive testing when you develop items it's very important that the people answering them understand what you're asking them, that they're answering what you think they're answering. So the initial development included a lot of cognitive testing with parents as well as looking at medical charts that when we got positive answers, did it show up in the medical chart, and then, you know, vice versa.

And then it's also been used in

hundreds, a couple, about up to 300,000 cases of data that we have in the national state surveys that there's been a number of analyses on. So it's been used by, you know, I mean it's much more than 23. The 23 is really a piece of the development study. So I'm not sure exactly what more you want me to say about that. But it's included and data has been collected and analyzed in hundreds of thousands of cases.

MEMBER BIALEK: Just a follow-up. So then for the numerator, if I'm a pediatrician and I ask the parent, "Did you complete the survey?" And the survey that was completed is something that in my practice, I pulled it off the Internet, it's not necessarily within the AAP's list. Does that count? What counts as the numerator?

CO-CHAIR McINERNY: It should be a standardized.

DR. BETHELL: I guess, you know, that's exactly the point of this measure is to make sure that when we're trying to find out if screening occurred that the questions that are asked are

getting as close to the bone that what happened was what was recommended, that it be a standardized developmental screening instrument that represents the content that this measure asks about.

And so it's, it's meant to make sure it's not as casual as what you just said, that it actually is an indicator that -- a standardized tool that includes the components that are recommended, both cognitive language and socio-emotional, are included. And so that's exactly what the purpose is. So you're making a really good point, you wouldn't just ask, you would, you know, include this.

CO-CHAIR McINERNY: And then to tie this to the plans, does the National Survey of Children's Health, does that ask the parents what --

DR. BETHELL: Yes.

CO-CHAIR McINERNY: -- kind of health insurance their child has?

DR. BETHELL: They do.

CO-CHAIR McINERNY: How specific is that?

DR. BETHELL: It does. And that's why, you know, barring -- there's a number of indicators in the National Survey of Children's Health that are aligned with quality parity from the ACA and we have a whole website on that, that are derived from the National Survey of Children's Health, which does ask about type of insurance. And we stratify it by type of insurance, of course whether they have special healthcare needs and socio-economic variables as recommended in the ACA.

So the data that is available through the use of this measure is able to be reported at the state level by whether this child had private or public health insurance.

And as many of you know, asking about the actual name of the health insurance company would be another step. But there's no -- you know, and I'm sure it's happening that some are using this measure locally. And that's, of course, something

they can do, and we support them to do. If people want to use these items because they want to include it in a more home-grown or tailored way of looking at quality in their site or in their health plan that at least they have something validated and standardized to use and then to compare themselves to the state and by a lot of sub-populations because of the availability of the data nationally and at the state level.

CO-CHAIR QASEEM: So, Christina, there's a lot of questions around the table. So one thing I'd appreciate it if you can just make them to the point and shorter responses.

Jane?

DR. CHIANG: So I'm a strong believer in the developmental survey, but I have a question regarding validity. So just because you do the developmental screening what happens afterwards and how do you validate it? I understand that it's been validated by AAP but what, what are the measures to say that this then makes an impact in the outcome? So I didn't hear that; can you

address that?

DR. BETHELL: It wouldn't, it wouldn't occur in this measure. There is a follow-up for those who are at risk based on screening included in the Promoting Healthy Development Survey, which is another measurement set in NQF. This isn't a measure of whether the child passed or didn't pass the developmental screening; this is whether developmental screening occurred or not.

Now, the issue of what do you do about it, the follow-up, after you find out about it is a separate measure. And that is a measure that's included in the Promoting Healthy Development Survey.

DR. CHIANG: Yes. Well, I think that for me it's hard to evaluate this. It's just, you know, the survey, the screening tool. So that --

DR. BETHELL: No, that makes sense. I think that the, of course the big question on the table for the American Academy of Pediatrics in putting the statement out was to only recommend something if it were going to lead to something --

DR. CHIANG: Okay.

DR. BETHELL: -- by way of early identification and intervention and school readiness and those sorts of factors. And that's, you know, exactly the right question. And I think with the core of, you know, how the recommendations that screening occur came about. And of course people continue to do a great deal of research around, you know, the importance of developmental screening. And it's been maintained as a recommendation throughout that, that time. But for sure it should continue to be evaluated.

CO=CHAIR QASEEM: Thanks, Christina.

Arjun?

MEMBER VENKATESH: Thanks. And so I don't know the details of the content there, but I think I am struggling a little bit with something Mike was struggling very early on which is how to conceptualize of this measure in terms of how it's operationalized and used.

And so I'm thinking of this measure -- and, Christina, tell me where I go off on this --

is that this is a patient-reported process measure and so it is a -- because the questions are of parents, right? And so I'm putting it preparing child together that's a patient-reported process measure.

And so the way this would in my head, and it's the level analysis, it's population, national, regional or state, and so I'm going to for the sake of example put that at either regional or state because I can get my hands around things at those levels that can use this measure. So if I have a state-dedicated agency and I want to operationalize and use this measure, I have to identify all the children between 10 months and 5 years that had any of the four types of visits: so a well preventive visit, a dental visit, a mental health visit or a specialist visit. And so I'm hopefully just capturing and doing that I'm thinking of that as I'm capturing any kid between 10 months and 5 years who has some form of access, right, to something.

And then I'm going to go to those

parents -- and this is where I think there's probably some measurement burden associated with the measure -- I have to go to those parents and ask them three questions and in order for them to meet the process measure. And so that could be valuable in the sense of that's my whole population. But this whole measure can be used and implemented and done absent our traditional healthcare system; right?

The health plan itself can make available screening via a variety of methods, online or whatever it is, to those parents and then go back and ask them whether or not they did the screening tool.

And so I think, I think what -- I don't know, help us understand what the measures actually does and how it's operationalized because I think that's how we have to evaluate it, not -- it's nothing to do with what's noted in the physician records or things like that.

DR. BETHELL: Yes. Yes. I mean the way it would work is if a state wanted to use this

outside of the already-existing data, so states and others that want to get the data now can go right now and find out what's going on in their state. So that's already there.

And we just described what the sampling frame was for the scoring of the measure. However, you just ask it, you can ask it of all parents of children zero to five. You can do it on a survey, like insert it into the CAP survey as another, as three items, which is commonly done for maternal depression screening, and other things get added in.

And then you score it on the back end. And so you just have to have the sampling information to be able to score it appropriately if you want to align it to guidelines.

So the reason the ten to -- 10 to 48 months is because of how the guidelines are set. But you can ask this question of all the parents and then on the back-end score it.

So it can be used independent of its inclusion in the National Survey of Children's

Health. It can be added to a developmental screen that's included in our online well-visit planner tool as a way to queue pediatricians up for whether screening has occurred. So it has application. And, of course, it's included in the Promoting Healthy Development Survey, which is an entire instrument dedicated to the contents of well child care.

And so it has a lot of flexibility for how it gets used. What's described here is giving a lot more information about how it is actually used in the National Survey of Children's Health so you understand that.

MS. KHAN: David, go ahead and ask your question.

MEMBER KROL: Hi. Just had a question again back to the question on the denominator. Dental visits are included in this. Can you talk about the literature that either suggests or expects developmental screening to take place in dental offices?

DR. BETHELL: Yes. I think that, and

you know what, the denominator that we're describing here is the denominator from the National Survey of Children's Health. And it's important to recognize that for a measure that's going to be used in a different context, the denominator would really be organized around the population at hand. And it's really just what you want to count as having had a qualifying visit.

And in this case through the National Survey, any kind of healthcare visit that was preventive in nature was included and with a lot of dialog and discussion that in the sort of theory of integrated care, you know, wherever the child goes there's a basic, you know, set of questions that need to be addressed around well care.

So the fact that dental visits is included, what you need to know about that is it's really to get a denominator. But, you know, it's almost all those children have, have other kinds of visits. So it's really just to not exclude them in case that's the venue through which they were receiving screening. And, frankly, screening is

something that is becoming more and more community-based and no-wrong-door based in many areas. So it was a generous inclusion.

MEMBER KROL: Yes, I think that's the point is it's very generous. And I would doubt that there are many, if any, dental offices that are doing developmental screenings or even expected to do developmental screenings in their office. And I think including them in the denominator it just doesn't seem like it fits there. Not that it couldn't or shouldn't happen there, but for Bright Futures we have the expectation of pediatricians and other child health medical providers to be doing that. But I don't think that that fits for the dental community.

DR. BETHELL: Yes. It's not only generous but it --

MEMBER KROL: Yes.

DR. BETHELL: -- adds children because if a child has a dental visit they've almost certainly had a well-visit. So I think it's more

-- I mean I can present that data if you want.

The other thing is the numerator in an application for a local level, the denominator needs to be applied to the population that is of interest. And this is really just describing in the National Survey. And, you know, in the analysis with our technical expert panel, which is not unlike yours, the data presented is that this is not capturing -- to include them is not really capturing more children, but it's a generous inclusion.

And so it would be real easy for anyone who wanted to change that to, you know, drop those cases if they wanted to stratify it by that. There would be very few cases of children who had a dental visit and not another one.

But that's actually a good point: I think that it would be nice to put a specific fact in there for that. So it is generous, but it doesn't mean that that's how -- you know, again if this measure is used locally, which it can be, certainly in the context of something like a CAP

survey or --

CO-CHAIR McINERNY: Christina, I have to cut you off. I really would, again, appreciate it if you can keep the responses short and to the point. And for the committee if there's new questions that will be appreciated --

DR. BETHELL: They're not yes and no questions. That's my problem.

CO-CHAIR McINERNY: Thank you. That's okay.

DR. BETHELL: If they were yes and no questions I would keep them really short. But I'll do my best.

CO-CHAIR McINERNY: Thank you.

Mike.

MEMBER STOTO: Three things. One is we're asked to approve this as it is, not with some other version of the denominator to be made up as we go along. That's just a comment, not a question.

Secondly, thinking back to when my kids were this age, the chance that I could answer this

accurately seems pretty slim. First of all, it would have to be that I was involved as opposed to my wife who filled out the thing. But, secondly, I might not know whether or not the thing that I filled out had met the standards that are referred to here.

My third comment is that I don't see anything in the material that was provided to us that suggests that even if the kids did this -- even if the parents did this survey for their kids that it would lead to better health outcomes. Maybe that's true. I can believe that would be true. But there is no evidence of that, of that presented.

DR. BETHELL: So the extensive testing with parents was done. To answer your first question, there's been a couple hundred tests to really make sure that parents were understanding it and felt they could complete it. And it's important that, you know, first of all developmental screening rates are extremely low even using this tool. And it needs to be anchor -- anyway, I'm not going to go into that. But it

was tested extensively with parents and addressing your first question.

The second is this policy statement and all of the research that's recommending screening have the burden of indicating that early identification is important and leads to better outcomes in terms of, first of all, early identification, which has an inherent value in it, as well as the opportunity to address developmental concerns before children enter school.

So there's a whole body of work in that that really motivated the development of this measure in and of itself but is not really something I can summarize without really going off time here.

CO-CHAIR McINERNY: Thank you, Christina. And that was the question, that it's missing from this measure right now. Eventually, of course, we may be able to provide it, but right now we don't have it in front of us.

Margaret.

DR. BETHELL: Actually that's not true.

CO-CHAIR McINERNY: We have to move on to the next person. Margaret.

MEMBER LUCK: Thank you. I'm just following on Jane's point and Mike's last point which is I believe as a committee we are being asked to evaluate the strength of the evidence presented relating what's being measured, meeting this measure and a positive health outcome. And I believe -- and this is a yes or no question -- I'm asking did the developer say, and I believe she did say, that evidence relating this measure to health outcome is not presented?

DR. BETHELL: It is presented. It's a limited venue for presenting it. The papers that are cited present that. Certainly the AAP policy statement, the pediatrics article looking at those who receive screening, do better things happen in terms of access to other types of services that we know they need, whether it's early intervention or mental health services and so on. So it's a domino for other types of process measures in access to care, which then in turn are linked to outcome.

So it's definitely a longer conversation but that evidence is embedded within reports and papers and things that are referenced in the materials that you have.

MEMBER LUCK: And so I just want to remind the committee that -- and it's been mentioned, thank you so much -- that you are evaluating the measure that's in front of you as currently specified. And it is your decision to decide whether the degree to which the criteria have been met. So if you feel that the evidence is sufficient based on what you have available in this submission, then you'd make your decision thereafter.

CO-CHAIR McINERNY: Thank you. Eric.

MEMBER FRANCE: This reminds me of the practicing pediatrician who added a standardized developmental questionnaire to my practice three-four years ago. And we've already as a committee have said that there is value for well-child visits between age 0 and 6 years based on the value of developmental screening and health

promotion with the last two measures.

Having a standardized questionnaire means that there's less variability across the practices about the questions that are asked and the opportunity to identify developmental delays is stronger. So I see this as a metric that can drive practices over time to use the standardized questionnaire for developmental screening. I don't feel the need necessarily to argue whether developmental screening has a value. I think we already decided that with our last few metrics we approved.

This is about creating some standardization and will a measure drive standardization's use over time.

For the person on the phone, did your work help you understand whether the questions that would be asked by telephoning the parent could distinguish between robust developmental surveys like the ASQ or the PEDS versus something that the doctor might have written up and is using with a short set of questions that may not have much value?

DR. BETHELL: Yes, it did. That was the original development process was really looking with working with practices that had been using the ASQ or not, PEDS or not and validating against that directly.

CO-CHAIR QASEEM: Mike, do you have a new comment or it's done? Okay.

So I think we had a good discussion on this and I think we can probably vote based on the discussion and evidence and all the content in terms of the importance of this measure; right?

MS. MUNTHALI: So we're, I do believe we're still voting, but we're going to vote on evidence first as part of the importance criterion.

MS. ROBINSON-ECTOR: Okay. So voting is now open for Measure 1385. And for those on the phone, option 1 is high, option 2 is moderate, option 3 is low, option 4 is insufficient evidence and option 5 is insufficient evidence with exception.

(Voting)

MS. ROBINSON-ECTOR: And, Ron, we're

still waiting on your vote.

MEMBER INGE: I'm on a mobile, so I'm not sure if it's going through.

MS. ROBINSON-ECTOR: Oh, you would have to tell us verbally.

MEMBER INGE: Four.

MS. ROBINSON-ECTOR: Thank you.

MEMBER INGE: All right.

MS. ROBINSON-=ECTOR: So all of the votes are in and voting is now closed.

Two voted high, 7 voted moderate, 5 voted low, 5 voted insufficient and 2 voted insufficient with exception.

MS. KHAN: We need 13, so. So consensus not reached.

MS. MUNTHALI: So consensus I think it needs to be in the gray zone. We will move on with voting on this measure because I think we have nine that -- is that nine? Yes. -- that are high and moderate. And we have 12 that are low, from low to insufficient with evidence, insufficient with evidence with exception. So we will move on to

performance gap.

MEMBER BIALEK: Let's see, how do I say it? I feel really dumb about this, about the measure itself. And I'm just -- can the developer just restate precisely what it is that would be published as the measure? Because I'm a little bit still confused on that about the issue of standardized, where they pull from the standardized tools.

The measure itself, as I've read through all of the background materials, doesn't seem to say that you have to use a specific set of standardized screening tools. Maybe it does and I'm just missing that. And so if that could be restated that would be very helpful of what precisely would be published as the measure.

DR. BETHELL: No, I understand. This is actually a measure of whether standardized tools were used as recommended. So it's recommended standardized tools be used, and this is a measure that's squarely meant to assess whether standardized tools were used. And the wording and

the way it's organized is meant to get precisely at that. So --

MEMBER BIALEK: And where do you specify where the standardized tools come from? I mean there could be a thousands --

DR. BETHELL: That's actually part of the AAP policy statement and the national movement around developmental screening. And the guidelines and recommendations for screening are centered on parent, standardized parent-completed tools. But this measure is meant to evaluate whether it occurred or not.

MEMBER STOTO: At the bottom of page 14, 1.b.2, there is some data there about performance steps. Is that, are those data based on the measure that's being proposed or on some other measure?

DR. BETHELL: Yes, it's from the first National Survey of Children's Health and the other pediatric paper updates for that. It's, yes, it's from the data, 2007 data, and it is this measure.

MEMBER STOTO: So, specifically, when

you say "only 30.8 percent of children have received all the content to..." is that based on --

DR. BETHELL: Right.

MEMBER STOTO: -- is that based on asking their parents whether they've had a standardized test like what's being proposed here or is it based on some other way?

DR. BETHELL: Yes. And it actually moves from --

MEMBER STOTO: Yes or no? I'm sorry.

DR. BETHELL: -- 19 point to 30 in line with increasing quality efforts.

MEMBER STOTO: You can't answer that question with "yes" because I'm asking you is it A or B. "A" is, is it based on asking their parents as proposed here in the measure or "B" is it estimated some other way?

DR. BETHELL: It's based on asking parents using the items that are in this measure.

MEMBER ASOMUGHA: So the provider asks the parents?

DR. BETHELL: No. This is a quality measure so the provider really -- I mean they can, they can use it in that way for sure, but this is meant to look at whether developmental screening is taking place as recommended in guidelines.

MEMBER ASOMUGHA: Okay.

DR. BETHELL: And the source of the data is the parent.

MEMBER ASOMUGHA: Right. Okay.

CO-CHAIR McINERNY: This is a set telephone survey from the National Children's Health, National Survey of Children's Health. So it's a telephone survey calling parents and asking parents using random digit dialing or something like that.

DR. BETHELL: The National Survey of Children's Health and the two data sets that are presented here was a national randomized sample that was done through telephone interviewing, yes.

MEMBER LUCK: In the measure document on page 18 they specify the numerator details and the denominator details. So the parents are

asked, Were you given a survey -- Did you ever receive a questionnaire asking about concerns with your child's development, communication or social behaviors? If they say yes, that's getting them on the road.

Then there are two more questions that they are asked. If they say yes to both of those, then they meet the measure. So parents who have children age 24 to 71 months are asked: Did that questionnaire contain questions about concerns about words or phrases the child uses or understands and how the child gets along with respondent and others?

So if a parent answers, yes, there was a questionnaire and yes to those two components, my understanding is then that child is viewed as having received a standardized developmental assessment.

MEMBER KROL: And that's good enough to tell you that it was either PEDS or ASQ?

DR. BETHELL: That's what the development and validity process was anchored to,

yes.

MS. ROBINSON-ECTOR: Voting is now open for Measure 1385 for performance gap. And for those on the phone, option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient.

(Voting)

MEMBER INGE: This is Ron, and I vote 3.

MS. ROBINSON-ECTOR: All votes are in, and voting is now closed.

Seven voted high, 9 voted moderate, 2 voted low, and 3 voted insufficient. So the measure passes for the criterion of performance gap.

CO-CHAIR QASEEM: Okay. Reliability. Some of these things we covered already in the initial conversation. But any new comments before we vote?

(No response)

CO-CHAIR QASEEM: No comments, let's vote.

MS. ROBINSON-ECTOR: Voting is now open for reliability for measure 1385. For those on the call, option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient.

(Voting)

MEMBER INGE: Three.

MS. ROBINSON-ECTOR: Oh. Hi, Chisara. We are just waiting for your vote. Chisara? Are you --

MEMBER ASOMUGHA: Sorry. It's four.

MS. ROBINSON-ECTOR: We have all the votes.

MEMBER ASOMUGHA: Did you get that?

MS. ROBINSON-ECTOR: Yes. Thank you.

We have all the votes, and voting is now closed.

One voted high, 5 voted moderate, 8 voted -- seven -- 8 voted low and 7 voted insufficient. So that measure does not pass on the criterion of reliability.

MS. MUNTHALI: So that means the measure has failed. It doesn't move on because

reliability and validity as individual criterion within scientific acceptability are "must pass."

Are there any comments that you'd like to add so that we can add those comments to the report and also any feedback you'd like to give to the developer regarding reliability and testing in general?

MS. KHAN: Arjun, any change?

MEMBER VENKATESH: I was just going to add that with respect to the reliability and validity testing that I think one of the things that was challenging is that what's presented in the worksheet is either like 23 or 15 parent interviews. And for me it seems like that, it's hard for me to get my head around that being a sufficient number of interviews under which to establish reliability of the data elements for something that is a parent-reported process, which I'm sure people struggled with.

And so I'm sure there's probably actually been other work done and maybe it just didn't get included in this. And then that comes

up again with validity where there's a lot of references mated to, which I agree with, that many parent-reported measures are in fact valid of healthcare communication.

But it should probably be specific to this in the sense that I think what we'd want to see is that when you ask parents whether or not they asked these questions, did that in fact reflect that they got structured screening done on a broader, larger sample population to know that the measure is actually valid.

CO-CHAIR QASEEM: Jane?

DR. CHIANG: So I think this is a good -- I think the measure itself is well-intended. But I think that it needs to be tied to outcomes for me to vote for this.

MEMBER ASOMUGHA: I would agree. This is Chisara. I would vote for a stronger link to quality would, would be helpful.

CO-CHAIR QASEEM: Yes, go ahead, Eric.

MEMBER FRANCE: I don't know, I guess I'd push back on those comments just because the

committee has agreed that well-child visits are important for developmental screening.

As a pediatrician, I see someone when I'm doing a set of screenings and I might do it differently than a colleague. Having the standardized questionnaires and promoting questionnaires I think is a valuable piece. And I don't need, I don't need to know the outcome evidence is there because I think it already exists.

This is a measure that places will go from 0 percent to 80 percent quickly if these kinds of things are measured and captured and shared over time. And so the standardized measure questionnaires for development that AAP and others have recommended are being variably used, low rates as we see from this data. Asking parents whether they received these questions would quickly jump our nation to a place where high levels of practices will be using them and standardizing how they ask about development.

So I don't need to see someone --

evidence that people quit if I advise them to quit as a tobacco user because I know that evidence is out there. It's the same thing with these development questions.

CO-CHAIR QASEEM: Robert.

MR. VALDEZ: I'd recommend that the developer, as they work through these issues that Arjun raised, also think about populations that speak languages other than English. Because obviously the small sample size, at least to me, represented that that was only tested in English speakers. And some of the concepts and issues that need to be questioned would require some reworking in languages other than English.

DR. BETHELL: You don't want me to say anything; right?

CO-CHAIR QASEEM: At this point probably I think that we can wrap that up and move on to the next measure.

DR. BETHELL: Okay.

CO-CHAIR QASEEM: Thank you so much though. We appreciate your attending the call and

providing some feedback and answering all the questions.

So Measure 2689.

MS. MUNTHALI: This is from the Dental Quality Alliance, and they are making their way to the table.

CO-CHAIR QASEEM: So thanks so much. Do you mind just kicking the discussion off, introduce the measure, and we'll go from there. And again highlight the important points, please.

DR. CRALL: Certainly. Thank you.

I'm Jim Crall. I'm Professor and Chair of Pediatric -- or, excuse me, Public Health Community Dentistry at UCLA, formerly Pediatric Dentistry. And I am Chair of the DQA's Measures Development Maintenance Committee and currently serving this year as chair of the full DQA. Joined by Dr. Jill Herndon here who is from the University of Florida, who is our lead contact person involved in the development and testing of the measures, working with us in a collaborative fashion. And Diptee Ojha, who is the lead dental staff for the

DQA now for our measures.

The measures that we bring forward to you today, and thank you for the opportunity to present the measures and answer any questions, we see very much as complementing the measures, the five measures that were endorsed last year, four of which were access and process measures, one of which was a use of service measure.

The measures, the two measures, new measures we bring to you today focus around emergency department use and children who, for caries-related conditions, are receiving treatment in emergency departments, that's one measure; and the other measure being whether or not those children who are seen in emergency departments for caries-related reasons actually then receive follow-up care, follow-up dental services.

And so the process by which we develop these measures, it started with a pediatrics work group that we have that identifies concepts. They then prioritize and recommend those measures to the

Measures Development Maintenance Committee. We do the scan, evaluate the background, the evidence and the information, develop some initial specifications and then actually work with Jill's group at the University of Florida to test these measures on full data from four programs in the state of Florida and the state of Texas: the Medicaid Program and the CHIP Program.

We think that these are important measures to develop some standardization around because while the peer-reviewed literature contains some information about these measures, and many times that's mixed with reports and data that relate to adults and children, we've identified a number of reports that various states are doing because this is an issue that's important to states because they are bearing the cost of this care in their -- through their Medicaid programs.

But again, there is considerable variation in the way the measures are reported and specified. And, therefore, we see the role of the DQA to help develop some standardization around the

metric.

The process, I already explained, measures development. The testing committee did work with Jill's group and came up with some final specifications and results of testing which have been forwarded as part of the application to NQF. The measure was taken to the full Dental Quality Alliance and approved by the full membership of the Dental Quality Alliance.

We refer to these as our ED measures. And actually reflecting last night and looking through some material, I think maybe we should call them the DD measures as a tribute to Deamonte Driver, who was the 12-year-old from Maryland who died as a result of tooth-related infection that then spread to his brain. Interestingly he, and tragically he had obtained care in an emergency room but didn't get the timely follow-up care and subsequently succumbed to that infection.

So I'll, you know, if we can flip to -- I guess, okay, you've got the slide there. The significance of the measure, clearly a high

percentage of ED visits for dental-related reasons are paid for by Medicaid. And a high percentage of those are actually due to non-traumatic caries-related reasons. There's literature on that, and the IOM has identified this as an indication that the systems of care are not working as we would like.

And really our framework for this is ambulatory care sensitive conditions, conditions that ought to be addressed in the primary care service sector and where care of this nature either presented to emergency rooms and receiving some form of care there, albeit usually just in the form of antibiotics and pain medication, not definitive care. Or in some cases there's a smaller percentage of these kids actually have to be admitted because the extent of the infection is so significant.

So that's the backdrop for it. The Medicaid --

MEMBER STOTO: Can I ask just a quick question, Doctor?

DR. CRALL: Yes.

MEMBER STOTO: In the last slide there, that IOM reference in '93, was that specifically with respect to dental or?

DR. CRALL: No.

MEMBER STOTO: Okay.

DR. CRALL: No. No, that's a more general reference to, you know, the way the measure's going to be used.

The American Dental Association has tracked this and the trends suggest that there's an increase in use of emergency departments for dental services over time. Most recent report indicating it's over $2 million -- $2 billion worth. And so that's -- it's $21 billion worth; right, Diptee? $21 billion worth.

No, I'm sorry, it's $2 billion worth and nearly two million encounters between adults and children. And 20 percent or so of those being in children. So the trends are not necessarily going in the right direction.

And with that I'm going to -- those are

the measures that you, that we bring forward to you. I'm sure you'll discuss them one at a time. And I will ask Jill just to comment on some of the questions that were raised and some of the preliminary analysis that was done.

DR. HERNDON: Okay, so there are the two measures. The first is the Outcome Indicator representing the failure in outpatient management, and the second is the Process Indicator related to follow-up of care. And these first specified and tested at the program level with a focus on children enrolled in Medicaid.

And so we looked at some of the opportunities to see some of the committee's concerns. And one of the questions that was raised by the committee was that link for the main measure, that link between prevention and caries-related ED use. So in addition to the literature that was cited in our application we also looked at data from the Centers for Medicare and Medicaid Services, giving us data for the two of the programs that we tested, the Florida and Texas Medicaid Programs,

which represent the highest and lowest use of preventative dental services, with Texas among the highest and Florida among the lowest.

And as we expected, we saw that inverse relationship with our caries-related ED measure, that Florida had about two-and-a-half times the rate of ED visits compared with Texas.

In terms of the follow-up measures from the questions related to that, one was that linkage again with follow-up. And about a quarter of visits, children visiting the ED for caries-related reasons have repeat ED visits. And we know that those visits are focused in the ED, the pair is not definitive; it's focused on pain management and infection control. And so but there are interventions that are focused on linking patients to, ED patients to that outpatient care, and that has shown improvements in reducing those repeat ED visits.

In addition to the relatively high rate of repeat ED visits, there is also evidence indicating that the longer the amount of time that

elapses without that follow-up care, the more likely it is that there will -- that that next dental encounter will be in the ED. And so, again, that follow-up time period we put a lot of thought into that and testing around that. And two time frames were identified: 7 days and 30 days.

There is a very short window, short time period for prescriptions. The ED care often results in short time frame prescriptions for that pain control and infection with the antibiotics. And so, ideally, all patients would be seen within seven days. The reality is and the difficulty of getting those visits is that in our testing we saw that more than half of kids in the highest performing programs still weren't getting follow-up within 30 days.

So we specified the measure for two time frames. There's the ideal and then there's the 30 day to move us on that path towards improvement so programs can mark their progress and at least getting first to 30 days and then moving towards that ideal. And there is precedent for that two

time periods in other measures that have been endorsed by NQF.

There is also the question about why look at visit to any dental provider as opposed to looking at the specific services that were received? And again it's getting at that idea that the critical first step is getting them linked to the dental care system. That more than half of kids, half to two-thirds of kids in our testing didn't even have follow-up within 30 days of any kind. So getting that first step in the process and then you move them into -- from episodic care into the maintenance care.

So, and again just highlighting that, those communities and programs are at the leading edge of doing interventions to improve linkages to follow-up. They are demonstrating improvements in reducing ED visits and repeat ED visits.

And of course we'd be glad to address any questions that the committee has as you go through your discussion of the measures. And we thank you very much.

CO-CHAIR QASEEM: Thank you. Very nice presentation.

Questions? Starting with -- Robert, why don't you? Okay, Mike, go ahead.

MEMBER STOTO: Thanks for the presentation. One thing that came out much better in this presentation is now this really relates to the quality of follow-up. And so I think that understanding that, I mean that's what I expected, but understanding that, that's important.

The other thing is I'm glad that you gave us the data on Texas versus Florida because also pretty much missing from here, except for two, two little bullets, is evidence connecting primary care to a reduction in ED visits for dental care. Is there, is there any other, is there no other evidence of that sort? There must be. And the one thing, I ask about usage in general rather than dental care.

DR. HERNDON: So in terms of -- you know, there, it was surprising that there wasn't as much evidence as we hoped. But people aren't

doing the things we hoped they'd do to support the application. As Dr. Crall noted, there are a lot of studies out there but they may include adults and children, and this measure is focused on children.

And we're trying to keep it pretty focused on the population that we had at hand. But we do think you start looking out at the different interventions, the different programs that communities are doing, you come up with a lot of studies that show that when you start doing these diversion programs, you start linking them to outpatient care, that they are seeing, we are seeing some substantive reductions of ED visits and follow-up visits.

We're trying to focus on those studies that have the broadest populations through our application, relying on national data. And those studies that had the greatest generalizability and so forth, there weren't a lot of those. But there's a lot of these smaller studies.

MEMBER STOTO: All right, just one

follow-up. The IOM did two studies that were triggered by this poor boy in Maryland dying. I don't know whether that has some evidence about this or not?

DR. CRALL: Not, not really a lot. There's two, two reports, one that sort of paints the landscape and defines the issues, another which gets into suggesting what, you know, what might be done to improve the situation.

So back to Jill's other point. You know, a lot of the reports that are there, particularly that relate to the first measure, you know, state of New Hampshire, state of Maine, state of Oregon. So there are state-level reports that haven't made their way yet to the peer-reviewed literature. And so, you know, we found them. They come to the same conclusions. There are bold headings in the executive summary saying, you know, that this is a failure to be able to address these problems or upstream. But that's the extent of the literature that we had to work with.

CO-CHAIR QASEEM: Robert.

MR. VALDEZ: Yes, clearly this first measure is a marker of access barriers and possibly outcome measures. And I'm glad that you showed the results from Texas and Florida because clearly this measure could be showing deficits in either availability, accessibility or, as you were trying to suggest, appropriateness of utilization, or under-utilization of appropriate oral care at the primary care level.

Do you have evidence that it's this latter as opposed to the availability and accessibility? Have you looked at that at all?

DR. CRALL: Let's see if I understand your question. We have seen data that speak to this issue about: Are people using emergency rooms just for convenience or just because it happens to be close or that's the only place they get care? And so and those data generally show that that's not the dominant sort of reason for seeking care there. It's, you know, I couldn't, I couldn't get in to see a dentist either because of the hours of operation or because of just general access to

care.

Now, Florida and Texas are two very interesting sort of states to contrast here because Texas for many years was a much lower performing state on the basic CMS measures, EPSDT measures. But as a result of a lawsuit that was settled, a federal lawsuit that was settled in 2007 and then subsequent changes made to that program, there's a significant expansion of the provider base. And that's why I think we see the increase and see the preventive services being used. So there is much broader access there now.

Florida is still in the throes actually of a federal case that's still being tried about access to care for both dental services and medical services. So, and I have actually looked at the data for Florida and the workforce data. And Jill's from Florida and her colleagues there in Florida look at that data as well.

Again, the issue doesn't seem -- I mean with some exceptions about rural counties and places that have a relative lower number of

providers -- but, you know, by and large the issue is not numbers of providers available; it's numbers of providers available to individuals who are covered by Medicaid.

MEMBER FRANCE: I think as we've been talking around these kinds of measures we sometimes wondered about: Is this a measure about access and primary care support, or is it a measure of health and well-being outcomes? And sometimes we kind of mix them all together as we present them.

And so you'll talk in here about your fluoride varnish and the prevention work that's being done. And that might point towards a metric that's really about demonstrating the reduced caries in populations over time. And I might be interested in simple incidence rates of caries ICD codes for both outpatient settings and in emergency rooms to sort of track those.

And yet as developers of the measures, you chose to use the ED as the visit. So that suggests it's more about access to primary care that you were interested in measuring to maybe

promote better dental access in a community.

So can you talk a bit about which way you went and why you wouldn't consider more just basic caries incidence rates?

DR. HERNDON: Again, this measure really was envisioned along the same vein as the other ambulatory care census condition types of measures that we see like the PQIs and so forth that you see around asthma and diabetes and so forth. And I think some of what the questions are getting to is --

MEMBER STOTO: You said "was" or "was not"?

DR. HERNDON: Was. Is.

MEMBER STOTO: Was.

DR. HERNDON: Yes, yes. So really envisioned along those same lines where there may be multiple factors that contribute to the reasons for those well-visit rates but it is a system-level measure. It's being measured at the program level where you would engage the various stakeholders to addressing that issue. And that when it gets to

the point where people are presenting to the ED at that level, that really you are seeing, as the IOM recognized more than 20 years ago, the failure in outpatient management and care.

And the focus is specifically on caries-related visits because that is something that can be influenced by outpatient management and prevention, early identification and disease management.

MEMBER FRANCE: Okay. I have two more quick ones. One was then if it is about access would I might have seen more about how your results were aligned with the infrastructure for dental care within communities.

So you did show us a slide today that showed 53 percent versus 13 percent, one simple measure surrogate, if you would, of the infrastructure for dental care. And yet I might want to look at more information that really shows a strong correlation between present access to dental care and the way this measure changes based on that.

May be a high level question which is if the organization is interested in having this endorsed as a measure to be used in different settings, should there be more experience of piloting it somewhere and seeing both the positives and the negatives that follow from doing it?

So, again, the information I see here is more about making sure the codes are correct and talking about large data sets. I don't see anything that's a study that says we tried this as a quality improvement measure in Florida, in Ft. Lauderdale, and we had these adverse events, impacts that we really didn't know would have happened when you try and do it, these difficulties and so on, to help better plan what the impact might be at the national level for it being used.

DR. HERNDON: I'll start and hand it over to Dr. Crall.

One of the things that we're seeing is a lot of states are doing their own studies. And we may already be seeing this as a significant issue. But part that challenges that is there are

different flavors of it. So we're not getting that consistency, that ability to compare across entities.

So it's very clear that this is an issue that's very important to states. And what we're bringing to it is we're bringing the consistency, we're bringing the validation of the codes, which has not been done. And so there's really an interest in using it. And we want it to be consistent. We want it to be valid. We want it to be reliable so that it allows for that comparison.

DR. CRALL: Yes, and I'll just say, you know, some of the people, or a couple of the people at least that were part of our pediatrics work group that identified the concept, have done some research in this area and published in the area but on a smaller scale. And so what we were really looking at is on a large scale program, such as a state Medicaid program, could we actually even capture these events and would we show differences, you know, across various stratifications,

characteristics of the population.

So that's the level at which we were focusing our initial efforts. I think just like some of the previous discussions this morning, we would look to move along that pathway as well once we establish that this is the most readily available large source of data that we could get, the Medicaid programs.

The couple of examples we had in there toward the end in the URLs for those programs, those are local programs, you know, hospitals in Minneapolis, a community-based program in Michigan. In fact, they have created what are called these diversion programs, which are literally, you know, not diversion to keep somebody from getting care but it's actually to establish that connection that they can actually get the definitive care they need, even though they present at an emergency room.

So, yes, we clearly would, you know, like to move along that pathway. We think as a first step it's looking to get the states to measure

this in their Medicaid programs and look to see some of this variation, and then start exploring about the consistency of that information and then having the states come up with strategies for how they can improve this. Because clearly we have seen at least some small examples of how it can be done on a local level.

MEMBER FRAZIER: I have more of a comment. When I was assigned to this measure, I found it interesting. Dental is not an area that I typically have focused any of the work we do in our community. But we happened to do a report on looking at non-urgent emergency department visits and primary care center visits. In 2013 I was looking at the report, and in looking at the report we did learn that the number one issue was toothache, and which was amazing to me. And that linking to primary care I thought was important when you do that. And I think secondly when I look at it, 32 percent were children.

So clearly it's been a gap that we have not made that linkage. And I think making this a

specific focus on dental, linking it to primary care makes sense. And I think that was the comment that was being made. And I think the linkage is critical.

So that's just my comment. I didn't -- when I saw the measure I was like, oh, why am I looking at this measure? Then I went back and looked at this report and I saw that you guys have made the linkage, and I think that's great. That's just a comment.

CO-CHAIR QASEEM: Arjun.

MEMBER VENKATESH: So I guess I have several comments on various aspects of this measure. I think first I think it's important. I think we should not overstate the importance. The data you guys have in your application from the National Emergency Department sample puts this at about 107,000 national visits per year, of pediatric, ED visits or dental care. So if you get 100 percent reduction we're only going to prevent 100,000 ED visits on a denominator of 130 million.

But it's I still think a very important

problem. It is probably from the, from working in the ED a very, you know, clinically salient topic or something that would be managed by better ambulatory healthcare systematics.

So given that you've got this one focus problem that you're focusing on, I think the questions are have are one is technical, one is more conceptual. The conceptual one is around alluded to around access. And to me this is a measure of access. I don't think we should overplay the parallels between this measure and the AHRQ PQI measures. Those are measures of truly chronic diseases that are present on every day.

So a patient that has diabetes and has both visits are hospitalizations for hyper or hypoglycemia, even in a well state in which the ambulatory system is working well, they still have that disease every day.

Dental caries can be a chronic disease for some portion of kids, yes. But for many, many kids it is going to be an episodic poor access issue. And so in the context of that you have a

measure that measures episodically poor access. I'm thinking about this measure and saying, okay, what does it mean? How do I interpret the score when I see the score? And so when I work in New Haven, there's the interpretation of this score is we do not have providers that accept Medicaid, period. So that's the problem. Right?

If I go to the adjacent integrated delivery health system and I choose integrated health delivery system because you guys chose level of analysis to be integrated delivery system not, say, state or some other level, their reason for a poor score may actually be that there is not availability of after-hours access or a variety of things that would make access to that ambulatory system more available.

And so the reason that becomes problematic is then when I think about interpreting the measure score, when we say that a higher score is bad, between two health systems it means very, very different things between those health systems. And so I get a little concerned when a

single's measure score is interpreted as one thing but means very, very different things across the level of analysis.

So maybe the fix is that the level of analysis has to be one where we're okay with both of those types of access problems being glommed together.

And then the specific question I had around the technical side is: When I read the numerator and denominator are we measuring beneficiaries or are we measuring -- or patients or are we measuring visits? And if it's visits, the reason I think it's problematic is because if it's really a visit-based measure then health systems that don't have access, where people do not accept, say, Medicaid or just don't have, there's no dental providers, things like that where it's a supply-driven access problem versus a process-driven access problem, those communities are going to do terrible because they're going to have repeatedly poor access.

The same patient will have five ED

visits for dental caries versus a system where you could say, okay, they get one follow-up visit and they can get linked back in. They're never going to get linked back in if it's a supply problem.

And so I would I think recommend that the measure I hope is constructed around beneficiaries where only one visit counts towards or can actually multiple, multiple ED visits count in the measure?

DR. CRALL: I'll comment to the first couple of, the conceptual and then Jill can maybe comment on the technical.

First of all, I mean I and a lot of literature now view dental caries as a chronic disease. What we're talking about in these measures are the severity when the severity of the disease, unaddressed through any care mechanism, hits a point to where symptoms start to develop, either in terms of pain, swelling, infections, et cetera, et cetera. So that's what these measures are focused on.

But the underlying disease process is

clearly a chronic disease. CDC refers to that; there's a wealth of literature on that. So that's where we're trying to move people in terms of the thinking about this. Given that most, thank goodness, most kids in the country, the more, tend to be the more well-off families in the country they don't hit this level; right? You know, because of a whole variety of things.

The second, in terms of the integrated health system and who's got sort of joint responsibility, that's why we were focusing this measure initially on the Medicaid programs because we believe that the Medicaid program actually sees both sides and deals with both sides. With the primary care medical, it deals with the dental care delivery system as well. And that's at the level that the responsibility and the accountability we think is integrated, given the fact that, you know, those programs tend to exist within states and silos as well.

But I mean that's where we -- that's why we specifically spoke to that approach to the

measure and the accountability. And, clearly, it could be moved into systems of care, would be ideally I think moved into systems of care. But again, systems of care where that, the mechanisms to deal with that in multiple ways, including dental care delivery and primary care medical delivery, are part of that system.

Do you want to address this?

MEMBER VENKATESH: Should we like for level of analysis, the reason I think this is a big issue is because we endorse the measure at a level of analysis, and so you guys put down integrated delivery system. Is it actually state, population of state?

DR. HERNDON: So, this is a challenge for us as well. And we may need some NQF guidance on this. As we requested their guidance on this because it is at the Medicaid program level. And we asked for their guidance of what do we select for level of analysis? And that was how we were counseled.

So that's what we did.

CO-CHAIR McINERNY: Okay, Ron.

MEMBER BIALEK: Two questions. I think it will be quick.

One is for the population that you're talking about, 0 to 20, is the coverage that they have cover both preventive and dental caries? Okay.

DR. HERNDON: Yes.

MEMBER BIALEK: Second is, are there any measures that currently exist -- and I don't remember all the measures from last time -- measures that currently exist or measures that are contemplated that get to the capacity issue such as use of mid-level providers like dental health aides?

DR. CRALL: The previous measures have what is really a pretty coarse measure, just are they using any services at all? So that reflects at least use of dental services. And then depending on how a mid-level, what category you're talking about, you know, we follow, we tend to follow the CMS 416 definitions, which call dental

services something that's services are provided by or under supervision of a dentist, and oral health services are services which are provided by someone other than -- supervised other than a dentist. So we follow those measures.

And, you know, are there other measures where -- the other measures we have then that were approved are things like, you know, did the kids, are the kids getting sealants? Are the kids getting the fluoride? Are they getting oral evaluations, which is a marker for the beginning of comprehensive care. So those are the measures you're already endorsed.

CO-CHAIR McINERNY: Ron Inge on the phone has a question.

MEMBER INGE: Thank you. My questions is would be: How do you track the individual patient from the ED to the dental office? Since those are usually two separate systems, how can you identify the follow-up care?

DR. HERNDON: So this, these measures are specified again for Medicaid programs, which

would have those medical and dental claims. And so and for any other integrated types of systems that would implement this, they would need to have medical and dental claims that could be linked at the patient level in order to track whether there was that follow-up visit within the certain time frames after the ED visit. So it does require both types of claims.

DR. CRALL: So you need to identify it.

MEMBER INGE: And so do those exist now?

DR. HERNDON: I'm sorry, I didn't, I didn't understand the question.

MEMBER INGE: In the study that you used, Texas and Florida, is there the ability to communicate that information now?

DR. HERNDON: To link the -- oh yes, we're able to link the medical and dental claims. Yes.

MEMBER INGE: Okay.

CO-CHAIR QASEEM: Sorry, Arjun. Let's vote on the importance of the measure.

CO-CHAIR McINERNY: And just to remind you, we're voting on the first of the two measures. This is the measure on ED visits.

MS. KHAN: I just want to add in that this measure is an outcome measure, so the evidence requirements are a little bit different. Just as a reminder, evidence requirements for health outcomes include providing a rationale that supports the relationship of the outcome to processes or structures of care. Our guidance suggests that if the health outcome measures agrees with the relationship between the measured health outcome and at least one clinical action identified and supported by a rationale.

MEMBER ASOMUGHA: Can I ask one question before we vote --

DR. HERNDON: Yes.

MEMBER ASOMUGHA: -- of the developer?

CO-CHAIR QASEEM: We've ended the questioning. Sorry.

MEMBER ASOMUGHA: Okay, fine. Thank you.

CO-CHAIR QASEEM: We're running behind.

MS. KHAN: This measure is 2689.

CO-CHAIR QASEEM: So everyone understands what we're voting here in the process because I think it's really important that we're all on the same page.

MEMBER BAER: Is this pass/no pass?

MS. KHAN: Yes.

MEMBER BAER: This is not just high/moderate/low, this is pass/no pass; correct?

MS. KHAN: That's correct. So Kaitlynn will read off the options for you in a little bit.

CO-CHAIR QASEEM: Everyone ready to vote? Let's go.

MS. ROBINSON ECTOR: Voting for evidence is open for Measure 2689. And option 1 is yes, and option 2 is no.

(Voting)

MS. ROBINSON-ECTOR: And, Chisara, we are still waiting for your vote.

(Pause)

MS. ROBINSON-ECTOR: Chisara, we are still waiting for your vote. Chisara, are you still on the line? Oh, okay, and your options are yes or no. You can vote verbally.

Thank you, all the votes are in and voting is now closed. Twenty voted yes, and 1 voted no. So the measure passes for the evidence criterion.

MS. KHAN: So we'll move on to performance gap.

CO-CHAIR QASEEM: Discussion?

(No response)

CO-CHAIR QASEEM: Okay, let's vote.

MS. ROBINSON-ECTOR: Voting for performance gap for Measure 2689 is open.

CO-CHAIR QASEEM: I ask do you have any issues, would you like to discuss?

MEMBER VENKATESH: I was just going to say one proposal that we change level of analysis from "integrated health system" to "health plan" since that's what Medicaid plans are and that's

what this was developed on and intended for.

And just one thing I just wanted, I asked a question earlier about double counting. And so is this a visit-level measure or a beneficiary-level measure?

DR. HERNDON: So a couple of things. The distinction between health plan -- I want to be careful with health plan versus -- I totally appreciate where you're coming from because we struggled with this as well because there's not a specific like Medicaid program level. But there's plans within Medi -- and that's not what this was designed for. This is really a system program level. So I don't know if a plan would be appropriate. And again this is where we kind of seeking NQF guidance when we were completing that. So I want to be a little bit careful about that.

But I will leave it to you all to kind of figure out which is appropriate. But I just wanted to kind of note that distinction.

And it is at the visits level. Again, it's viewed as a systems level indicator and, as

with many conditions, there may be a lot of reasons why individuals end up at the ED for something that's preventable. And the idea is there's a quality indicator that there is a failure of outpatient management. And that can be at the systems level failure. And so but there may be for a lot of conditions a lot of different reasons that contribute to that.

And those reasons may have different weight across Medicaid programs. But the programs, once they identify what the gap is, then that's where they need to identify what are the main contributing factors and target those. And those won't be the same from program to program. So they need to target those factors that are influencing those programs.

So and it is at the visit level. And so there would be repeat ED visits, including the programs we tested we saw that like 90 percent of visits were from -- were just one visit, that there was a very small percentage that constituted repeat visits. So it wasn't a big factor in the programs

that we looked at.

MEMBER CARRILLO: I value Arjun's concerns. I don't personally understand why -- I don't understand why there's not an analogous consideration as to PQI measurements in terms of a framework.

DR. HERNDON: I'm sorry, I don't know that I understood your -- I'm sorry, I don't think I understood your question.

MEMBER CARRILLO: In terms of level of analysis, the use of the delivery system which is Medicaid, why are we not using similar considerations as we do in PQI measures? I think that this measure, as has been stated before, has a lot of analogy with PQI measures, and why don't we look to PQI measures in terms of what our denominators are?

DR. HERNDON: So the PQI are community, population-based measures, the ones that I am familiar with, and they're per 100,000 people in a community. And so this was designed for Medicaid programs as the primary target against -- the

Dental Quality Alliance was formed at the request of CMS, and a big target user for this would be Medicaid programs. And so in thinking about translating that, those types of measures to a Medicaid program we also followed the example that was used in the event-based measures are frequently reported in terms of member months.

And we followed the approach used by the Centers for Medicare and Medicaid Services in their adult core measures. But when they adopted the PQI measures they did it for 100,000 member months. And we wanted to be consistent with that reporting across Medicaid programs so that, you know, the adult measures, the pediatric measures that they're reporting in consistent bases for these event-type measures at 100,000 members months. So we did the same adaptation that they did for the PQI measures.

CO-CHAIR McINERNY: Okay, let's vote.

MS. ROBINSON-ECTOR: The original poll is still open. And if you wish to change your vote you can just click the number that you wish to

change it to.

(Voting)

MS. ROBINSON-ECTOR: And, Chisara, we are waiting on your vote.

So option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient.

Thank you. All the votes are in and voting is now closed. Twelve voted high, 6 voted moderate, 2 voted low, and 1 voted insufficient. So for the criterion of performance gap the measure passes.

MS. KHAN: So we're on reliability now. Are there any questions on reliability?

(No response)

MS. KHAN: Let's take a vote on reliability.

MS. ROBINSON-ECTOR: And for those on the phone, option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient.

(Voting)

MS. ROBINSON-ECTOR: So all the votes

are in and voting is now closed.

Seven voted high, 11 voted moderate, 1 voted low, and 2 voted insufficient. So for the criterion of reliability the measure passes.

MS. KHAN: Any comments on validity?

(No response)

MS. ROBINSON-ECTOR: Voting is now open for validity. For those on the phone, option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient.

(Voting)

MS. ROBINSON-ECTOR: All the votes are in and voting is now closed.

Six voted high, 14 voted moderate, 1 voted low, and 0 voted insufficient. So for the criterion of validity the measure passes.

MS. KHAN: Are there any comment on feasibility?

(No response)

MS. KHAN: Okay, let's take a vote.

MS. ROBINSON-ECTOR: And for those on the phone, option 1 is high, 2 is moderate, 3 is

low and 4 is insufficient.

(Voting)

MS. ROBINSON-ECTOR: All the votes are in and voting is now closed.

Twelve voted high, 9 voted moderate, 0 voted low, and 0 voted insufficient. So for the criterion of feasibility the measure passes.

MS. KHAN: Lastly, usability in use. Any comments?

(No response)

MS. ROBINSON-ECTOR: So voting for usability in use is now open. And for those on the line, option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient information.

(Voting)

MS. ROBINSON-ECTOR: All the voting is in and the poll is now closed.

Ten voted high, 10 voted moderate, 0 voted low, and 1 voted insufficient information. So for the criterion usability in use, the measure passes.

MS. KHAN: So we're going to go to

overall suitability for endorsement. Are there any comments that anyone wants to make before we take a vote?

CO-CHAIR QASEEM: The change that Arjun proposed, are we going to keep that in mind in terms of and figure it health delivery system when you're voting on the final one or no? Or are we voting on what we're voting that what's been presented?

MS. KHAN: We're voting on what's been presented to us by -- even if we were to change level of analysis, it's just terminology.

We're voting on what's presented. But even if we were to change the terminology we're using right now it wouldn't change any of the testing or specifications. We can certainly follow up with the committee about whether it should fall under health plan or integrated delivery system and follow up with you after the meeting if that's something you guys are all interested in.

MEMBER VENKATESH: Or can we do the

same thing as come back in one year with a revision or something along those lines?

MS. MUNTHALI: Yes. And we can work with the DQA as well and see what's feasible with regards to timing. But I think some of the two may have just been a selection from our drop-down in our system. And we can make the clarification in the narrative as well. But for, you know, expanding it if it goes beyond that level of analysis, that will require changes to the specifications and testing. And we definitely want to make sure we review and to make sure it's feasible, so.

MEMBER STOTO: Can I just make the comment that this really will be an important issue as we move towards more population level measures. And I think it may be more a problem with the categories that you have rather than with the proposal you have on the table.

MS. MUNTHALI: And it's interesting you mention that. We are actually working with a group of developers, and DQA is part of it, I think

Krishna is on that, to develop a panel to go through our submission form. You know, because we realize that we may need to make some changes. The questions that we're asking and some of the drop-down menus may not make that much sense to everyone, so we want to get input from developers. And so hopefully you will see some positive changes very soon.

CO-CHAIR QASEEM: Arjun, are you okay with how the group is going to proceed with this?

MEMBER VENKATESH: I am. I am okay with the measure totally the way you guys have specified it. I just think it's probably just a difference of words. To me this is a plan measure: Medicaid plans are plans. It makes a ton of sense to implement them across Medicaid plans. A state Medicaid program could do this across their plans.

I think it's probably just the differences in terminology. My only fear would be if we mistakenly put out a report that says this measure was endorsed as an integrated health delivery system measure and then it got used that

way to say, oh, this is how, you know, this one small health system does within a community compared to this other health system. If you start comparing it that way it would be a misapplication.

MS. KHAN: And we can certainly reflect that in the report, that that was a clarification the committee wanted to make.

MEMBER FRANCE: I just want to say that the piece that still has me a little stuck on this is that the measure is about accessibility to outpatient dental care, and we've seen data about Florida and Texas for plans. Have we really seen enough to be able to say this is a consistent measure that in all its gradations, 36 percent versus 20 versus 15 versus 2, it correlates nicely with the infrastructure of outpatient systems? We see it, we see it a bit in Texas and Florida, but not in a large way.

And it seems to me that since the general goal of this measure is to reflect the quality of outpatient care, of dental caries -- dental care to prevent caries, is there enough body

of evidence here or me to endorse it as such. That's where I am sort of.

MS. OJHA: So there are some studies that do specifically look at -- so there was an Alabama CHIP study that we cited in our allocation that followed kids for a minimum of three years and looked at if they got preventive care versus those who did not were they more likely subsequently to have lower rates of non-preventive dental service use, which included both treatments and emergency department use. And they found that, yes, they did have lower rates of subsequent non-preventive dental use and lower subsequent non-preventive dental expenditures.

And that was one of the studies that was focused solely on children.

MEMBER FRANCE: Yes, thank you. I remember that. It was, it was more this question that here's a population that gets a ranking of "F." And your new measure scores 12, here's a population where they get a ranking of "C" for their infrastructure and they get 20 percent, and then

here's one that gets an "A+" and they're getting, you know, something better in terms of the rate.

Just if that makes sense. That was sort of the level of data that I might have expected around this kind of a measure to access.

DR. CRALL: Yes. And I think where we're a little stymied on that again is that for one of the parameters that we presented here, preventive services, that's an accepted measure. There's CMS 416 reporting. We have a, you know, we have a DQA- and NQF-endorsed measure that relate to those elements. What we don't have is any standardized measure of that other element.

So, you know, within the database that we had available for testing that's the way we looked at it and then looked to the whatever literature was there. But certainly once someone gets a standardized measure for the ED use then we will be able to start scoring those relationships and states will be able, as Jill said, it's obviously going to be multi-factorial, but they will start looking into those things with this.

MS. ROBINSON-ECTOR: Voting is now open for overall suitability for endorsement. And for those on the call, option 1 is yes and option 2 is no.

(Voting)

MS. ROBINSON-ECTOR: All the votes are in and voting is now closed.

Twenty voted yes and 1 voted no. So for Measure 2689, Ambulatory Care Sensitivity Emergency Department Visits for Dental Caries in Children, the measure passes for recommendation for endorsement.

MS. MUNTHALI: Sorry, we're running a bit behind and so we're trying to figure out how to adjust our schedule. So just one minute.

(Pause)

MS. MUNTHALI: What we're debating is whether to go to lunch now. We just need to confirm that that's okay with ARC who is scheduled to present now. And they're, I don't know if they're in the room. They're in the room. So I think they're finding, unless they have a conflict right

afterwards.

CO-CHAIR QASEEM: It's 12:20, I think if we're a little five or ten minutes behind it's better to finish. Is it okay? It's two measures. Oh, okay.

MS. MUNTHALI: Are you all okay with going forward with the dental measure and being a little late for lunch?

MEMBER ASOMUGHA: Yes.

MR. VALDEZ: Yes.

MS. MUNTHALI: Okay.

MEMBER ASOMUGHA: I'm fine with this.

MS. MUNTHALI: And so we'll ask the DQA if there is anything new. If not, I think we can start the discussion, the committee discussion. So that will be great. If you want to add anything this will be the time to do that, but if not, we can proceed.

MS. ROBINSON-ECTOR: So any discussion on evidence? Robert and Mike.

MR. VALDEZ: I had a hard time finding any evidence presented, so maybe you can clear up

for me this inter-rural decision for cut points at 7 days and 30 days. Did I miss the evidence that you presented or is there any evidence?

DR. HERNDON: So in terms of the evidence there's not a lot of evidence around specific time frames of exactly this number of days is the perfect time frame. But what there is evidence around is that the longer, there have been examinations of 30 days versus longer periods and so forth, in that when you go allow for a longer time to elapse, the more likely that that next dental encounter will be in the ED rather than in an outpatient setting where they can get definitive care. So that's one piece of evidence.

In looking at what the general clinician recommendations are in terms of expert consensus, sooner is better was kind of unanimous. And when you look at the patterns of prescribing by ED's for what's really pain control and infections, antibiotics, very short time frames, there is a referral to a dentist. Frequently that referral is as soon as possible.

So ideally we were looking at thinking about the time frame that they have, the prescriptions, looking at, looking at our own data in terms of the amount of follow-up at 7 and 30 days, identifying that ideally everybody would be seen within 7 days. When their prescriptions are running out, to get into that link into the outpatient system of care. But practically, that, securing that appointment in that time frame, as we talked about with other measures, the realities are every child will not get in. At this point even within 30 days we're seeing most kids are not getting that follow-up and that linkage to outpatient care where they can get the dental treatment that they need.

And so having those two time frames as they start moving towards that ideal, having the 30 day as the marker, and that's consistent with other NQF-endorsed measures of follow up that use 7 and 30 days.

MR. VALDEZ: May I just follow up. So this measure in fact is holding folks accountable

for what may be systems issues of accessibility as we've talked about in the previous measure, as opposed to quality issues. Is that my understanding? This potentially holds health plans accountable differentially because of different kinds of access problems as opposed to the actual quality issue.

DR. HERNDON: Again it's, again it is the systems level, program level, it's at the Medicaid program level, so again there may be different factors and it will tie in to those access issues. But it's getting into, you know, there's that process of care: are they getting that needed process of care? And as with many process measures, that will be related to access, as are most process measures do connect to access issues as well as other types of issues.

DR. CRALL: And that's why we left it at the level of the Medicaid programs because we do believe that's where the accountability is.

MS. MUNTHALI: And so, Mike, Jason, Eric?

MEMBER STOTO: So that last thing you said, that process measure is related to access, that's actually generally not true. The process measures have to do with what happens to people when they get into the doctor's office or the hospital. But it does bring up an important issue of whose care is being assessed here? Who's the accountable party? And I guess you're thinking that it's still the Medicaid rather than -- and the other -- so you say yes?

DR. CRALL: Yes.

MEMBER STOTO: Yes. Okay. And the other just clarification question I have is what counts as a success? Is it being seen by a dentist or by -- I mean if they came back to the same emergency department that would not count; right? It would have to be a dentist?

DR. CRALL: Yes.

MEMBER STOTO: A licensed dentist or, yes. But it doesn't matter where it happened, it's just who.

DR. CRALL: And the Medicaid dental.

MEMBER STOTO: Because I think that could be stated a little more clearly.

DR. HERNDON: Okay, thank you.

MEMBER SPANGLER: The numerator for this is 7 days, a visit within 7 days and a visit within 30 days; right? It's "and"?

DR. HERNDON: So there's two ways it's reported, 7 days and 30 days.

MEMBER SPANGLER: Okay. Okay, so -- okay. Because the description in the numerator has both but you have two ways?

DR. HERNDON: Right. There would be a 7 day follow-up would be reported and then 30 day follow-up would be reported parallel to similarly endorsed measures.

MEMBER SPANGLER: Got it.

DR. HERNDON: Yes. Thank you.

MEMBER SPANGLER: Thanks.

DR. HERNDON: Thank you.

MEMBER FRANCE: I'm curious about the outcomes from your chart audits for what happened in the dentist's office where I see on page 66 you

have a table that shows that about 29 percent of the children or persons under 20 had restorations done at the visit. At least that's what was billed.

And I'm just wondering if I'm reading that table right. So --

DR. HERNDON: Can you reference me to that table?

MEMBER FRANCE: Page 66 there's a table that's showing agreement between dental record administrative data. So you have concordance but you also have a column that's called "prevalence." And does that mean under restorations .291 means that 29 percent of the visits had a restoration occur at that visit?

DR. HERNDON: Yes.

MEMBER FRANCE: And so that made me just wonder because I don't, I don't know what -- Go ahead. I'm sorry.

DR. HERNDON: No, you go ahead.

MEMBER FRANCE: So if I have a swollen face and a swollen tooth in the emergency room and

I'm told to go to the dentist, it's only a third of the time that I actually needed restorative care done or a sealant and --

DR. CRALL: I can comment on that. So depending on the nature and extent of that infection it might be appropriate to actually provide a restoration of some type. It might be an interim restoration or it might be, you know a more conventional ministration that anyone would get if they weren't in an acute situation. But it may not be appropriate to provide a restoration at that point because what happens is you seal up that tooth and there's gases being formed as a result of that infection, and you blow that, you'll get to Deamonte Driver.

MEMBER FRANCE: So I think the reason I ask is that either the measure itself has some issue where other kinds of visits are coming in that you wouldn't necessarily want from sort of the process, logic model of what the metric is supposed to do, or you might say that 30 percent is from a face value from a dentist's perspective that feels

about right. And I'm not sure which of those two it might be.

DR. HERNDON: There's two separate cases for the validation. And I thank you for the opportunity to kind of clarify what we were presenting and where.

The validation of the dental codes to in terms of that the CDT codes that we see represent the services that are performed in the dentist's office. That was used broadly throughout, across a much broader group of children, not just ones who went to the ED. So that was 29 percent across a random sample who had any type of visit, not necessarily subsequent to an ED visit.

However, we also did look at, and we may not have reported this, and there was a lot of data that we looked at that we didn't include in the application, for obvious reasons, but not to have an overwhelming amount of information. But we did look at the CDT code patterns for those visits following the ED visit. And we saw some pretty consistent patterns because in some cases that

first visit would have a specific surgical service and so forth, but a lot of times what it would be is that oral evaluation and diagnostic imaging where then there would be another visit where they would get that care.

So usually it's phased because they're assessing what is exactly the problem. And then they're doing a treatment plan that varies according to the reason that they were seen in the ED. And so that's going to be a little bit variation where you'll see different codes. Which is probably the reason why specific codes were not specified.

And it's getting that access piece, which also is similar to other endorsed measures, the follow-up, that the specific services are not identified in those measures but rather are they connecting to outpatient care. Because that's the big issue is that first piece is just getting them posting the outpatient care. So when we look at other follow-up measures that have been endorsed, they also are not service specific.

MEMBER INGE: So for the kids that, so say a kid comes in within 7 days, they would, whether they get a restoration or whether they get an evaluation and then -- no restoration but are asked to come back later, that, that visit at 7 days would qualify, would be a success --

DR. HERNDON: Yes.

MEMBER INGE: -- according to this.

But if they didn't show up for that follow-up visit it's a failure.

So I guess I'm a little concerned about the numerator in this. And maybe I'm jumping the gun. I was going to say this later, but now that we're talking about this I think it's important to point out it seems to me that any dental visit after an emergency department visit is not an appropriate numerator. The numerator should be something having to do with the disease itself, the dental caries.

So if I -- so the medical example might be if I go to the emergency department for an asthma exacerbation and I have a follow-up visit at my

doctor's office within 7 days to get a foreign object pulled out of my nose, that's not a success; right? It's something completely different or has nothing to do with the disease that I went to the emergency department with.

So I'm struggling with -- and the example you just gave that I didn't even think of was, you know, it's so great, I got in within 7 days, but I didn't get my problem addressed because I had to come back later and I didn't come back. So I'm a little worried about the numerator in this. I think the numerator has to be the more specific to the disease process that the person went to the emergency department for.

Does that make any sense?

DR. HERNDON: Yes. I have a, I have a couple of responses and then I will let Dr. Crall jump in too from the clinical perspective. I actually really like the asthma example, that kind of measurement perspective, because part of what we see with quality measurement is we don't always start with the ideal because we are so far away that

we need stepping stones to get there.

So when we see that even in the best-performing programs half of kids are seeing any kind of dental provider, that's a starting point. And what I like about the asthma example is for years and years one of the only endorsed measures in the outpatient study were the program medications for asthma. And it didn't look at compliance or anything like that. And so that's what everybody was driving towards for a long time.

As they got really high on that bar, performance got really good. We'd consistently see a lot of plans at 80, 90 percent, 88, 90 percent. We started introducing new measures looking at compliance at different thresholds, 50 percent and 75 percent, like having different follow-up periods. And then they added another, the asthma medication ratio. And the consensus has been so good with that initial measure that they are looking towards retiring that measure because I really think there's, there's not a big performance gap anymore.

And so that's where we would like these measures to get to but we need that starting point. And given where we are, this is where we start. And then we can start thinking about shortening those follow-up periods, looking more specifically at the specific types of care received and how quickly it's received. But this is where we are at this time with the dental care system.

So I don't know if you want to talk from a clinical perspective about the nature and content of services? I would imagine with dental the range of different things that would be done would be less than going in to see a physician.

CO-CHAIR McINERNY: We have to move along. Margaret?

MEMBER LUCK: Thank you. I am still back at the question what evidence was provided in the submission form linking the health process, which is this follow-up visit within 7 or 30 days following an ED visit, caries related non-urgent ED visit. What evidence was provided that that follow-up care is linked to a health outcome? And

that's -- I didn't find it in the submission form but maybe you can help me with that.

DR. OJHA: We have instances of case studies that were done throughout. There are a few studies from Michigan that are actually directing patients using community dental health coordinators and that have had an impact on reducing ED visits.

We've also gotten case studies from Hennepin County in Minnesota that are also employing a similar, similar program.

There is a third case study that we did find in Kansas City, University of Kansas Medical Center, that actually are diverting ED-related patients using again their health coordinators and putting them in touch with outpatient dental clinics and federally qualified health centers where the patients are being followed up.

So we have incentive of real world case studies that we do know of, but there aren't any peer-reviewed articles to really point as such.

CO-CHAIR McINERNY: Okay, last two

questions. Jason.

MEMBER SPANGLER: I'm still getting hung up on this double denominator -- double numerator because if somebody does do the 7 day one, are they excluded from the -- so because, because you could have someone who does see a dentist within 7 days who doesn't recommend any more follow-up. They say, you know, come back and see me in three months. But then they would get dinged, so to speak, for not fulfilling the 30 day; right?

DR. HERNDON: No, they would be in the 30 day as well. The 7 day is a subset of the 30 day.

MEMBER SPANGLER: Oh, okay. So --

DR. HERNDON: Yes, yes.

MEMBER SPANGLER: Okay, so if you do the -- Okay.

DR. HERNDON: Right, right.

MEMBER SPANGLER: So it's just it's a subset. I got it.

DR. HERNDON: Yes. Thank you.

MEMBER SPANGLER: Okay. That makes

perfect sense. Thanks.

DR. HERNDON: Thank you for the clarification.

MEMBER SPANGLER: Sorry about that,

DR. HERNDON: No. Thank you.

CO-CHAIR McINERNY: All right, last one. Arjun.

MEMBER VENKATESH: I guess for me I think the crux, and you've said that the evidence is good is around that a follow-up visit after a month from that visit is linked to reducing future ED visitations. And I think that that's probably the safe outcome that you can think of linked to this measure. I think that's reasonable. And I think it probably measures that care transition.

And so I think to me that's how I'm framing my thinking about the evidence and thinking about the outcome on this one.

MEMBER STOTO: Is it in the document, that evidence?

MEMBER LUCK: I saw that one study from Alabama in the, in the document.

DR. HERNDON: And also there's the -- I'm not sure you how you pronounce his name, but Okunseri and Pajewski they, they looked, they tracked to different levels of follow-up and found that the longer amount of time that elapsed for follow-up, the more likely that next encounter would be in the ED rather than in outpatient.

And then there are other studies, localized studies where interventions focused on follow-up reduced repeat ED's that were used.

CO-CHAIR McINERNY: Okay, let's vote.

MEMBER STOTO: I'm sorry, I don't see that Alabama thing, even that cited in here. I'm searching for Alabama.

DR. HERNDON: Oh, I think that that study, that was not used in support of this measure. That was for the main measure, and that's not one that we were citing in support of the follow-up, that was linking prevention to ED use.

MEMBER STOTO: Okay.

DR. HERNDON: And the Pajewski -- I'm not sure how you say his last name so I apologize

if I'm butchering his name, and Okunseri article.

CO-CHAIR McINERNY: Okay, let's vote please.

MS. ROBINSON-ECTOR: Voting for evidence is now open. And for those on the call, option 1 is high, option 2 is moderate, option 3 is low, option 4 is insufficient evidence, option 5 is insufficient evidence with exception.

(Voting)

MS. ROBINSON-ECTOR: If everyone could just vote one more time, we're missing two votes.

CO-CHAIR McINERNY: A couple people may be getting hypoglycemic maybe.

(Laughter)

MS. ROBINSON-ECTOR: Thank you. We have all the votes and the poll is now closed.

Zero voted high, 11 voted moderate, 5 voted low, and 4 voted insufficient, and 0 voted insufficient evidence with exception. Yes, so that would fall under the gray zone which is consensus not reached.

So we'll keep voting.

MS. KHAN: Are there any comments on performance gap?

(No response)

MS. ROBINSON-ECTOR: Voting is open for performance gap. And for those on the line, option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient.

(Voting)

MS. ROBINSON-ECTOR: Looks like we're missing one vote.

All the votes are in and voting is now closed. Three voted high, 12 voted moderate, 4 voted low and 1 voted insufficient. So the measure passes on the criterion performance gap.

MS. KHAN: And on to scientific accessibility and reliability. Are there any comments?

(No response)

MS. KHAN: Okay.

MS. ROBINSON-ECTOR: Voting is now open for reliability. For those on the line, option 1 is high, option 2 is moderate, option 3

is low, and option 4 is insufficient.

(Voting)

MS. ROBINSON-ECTOR: Okay, it looks like we're missing one vote. So if everyone could prepare that one more time.

Great. So all the votes are in and voting is now closed. Three voted high, 10 voted moderate, 7 voted low, and 0 voted insufficient. So the measure passes on the criterion reliability.

MS. KHAN: Any comments on validity?

(No response)

MS. KHAN: All right.

MS. ROBINSON-ECTOR: Voting is now open for validity. And for those on the line, option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient.

(Voting)

MS. ROBINSON-ECTOR: All the votes are in and voting is now closed. Two voted high, 3 voted moderate -- 13 voted moderate, 5 voted low and 0 voted insufficient. So for the criterion validity the measure passes.

MS. KHAN: And on to feasibility. Are there any comments from the committee?

(No response)

MS. KHAN: Okay.

MS. ROBINSON-ECTOR: Voting for feasibility is now open. For those on the line, option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient.

(Voting)

MS. ROBINSON-ECTOR: Okay, all the votes are in and voting is now closed. Nine voted high, 8 voted moderate, 2 voted low, and 1 voted insufficient. So for the criterion of feasibility the measure passes.

MS. KHAN: Any comments on usability in use?

MS. ROBINSON-ECTOR: Voting for usability in use is now open. Option 1 is high, option 2 is moderate, option 3 is low, and option 4 is insufficient information.

(Voting)

MEMBER ASOMUGHA: I'm sorry, did you

say feasibility or usability?

MS. ROBINSON-ECTOR: Usability in use.

MEMBER ASOMUGHA: Okay.

MS. ROBINSON-ECTOR: Okay, all votes are in and the poll is now closed. Six voted high, 9 voted moderate, 4 voted low, and 1 voted insufficient information. So the measure passes on the criterion of usability in use.

MS. KHAN: Are there any final comments before we go to overall suitability for endorsement?

(No response)

MS. KHAN: Okay.

MS. ROBINSON-ECTOR: Voting for overall suitability for endorsement is now open. And option 1 is yes and option 2 is no.

(Voting)

MS. ROBINSON-ECTOR: Okay, all the votes are in and voting is now closed. 13 voted yes and 7 voted no. So Measure 2659, Follow-up After Care Emergency Department Visits by Children for Dental Caries passes for recommendation for

endorsement.

MS. KHAN: Okay, so at this time I think we're going to break for lunch.

CO-CHAIR McINERNY: Sounds great.

MS. KHAN: And we'll reconvene at 1:15.

CO-CHAIR QASEEM: Before we break for lunch, well, is that okay, can I ask for something? Can I get some feedback from this morning's session, things you feel like are helping out in terms of how we're evaluating the measures that might help us in the afternoon session as well, or any general comment I'd appreciate that I think. Starting with Arjun.

MEMBER VENKATESH: And I mentioned this to some people earlier but I think it would help to know if measures of healthcare access are going to sit in this standing committee as opposed to just measures of health and well-being outcomes that I think we'd kind of originally centered around? And the reason that matters is that the models that we use to measure evaluation are built on really effectiveness measures, originally.

Right? So, can you measure something, is it effectively done, does that improve a health outcome?

And so they're not -- they don't fit well. The documents are square peg/round hole when we try to do access measures. And so I just I think it would be valuable to know from a trust perspective where those access measures are going to sit. And if they're going to sit here, I think we need some guidance on how to think about those measures and how to apply the criteria.

MS. MUNTHALI: Yes. And, Arjun, we had that discussion earlier today. And I think it would be great during the gaps discussion that we have later on this afternoon. And it's possible add-on work for the committee when we're thinking about off-cycle when we don't have measures, to start thinking maybe there are frameworks that the committee can work on. So we started kind of thinking about some ideas preliminarily.

MEMBER FRANCE: I would just echo that and say that I think our voting this morning is

probably this mix of the both. And so things are passing and being endorsed by NQF by a committee that some of them are voting based on this is an acceptable access issue and some folks may be voting on it as a health and well-being kind of reasons. And so we don't have that clarity or separation of the two so that we can at least call it out.

MEMBER LUCK: Is that reflected in the voting where there a moderate and insufficient exception? When you got that and then that somehow added up to a consensus. And it didn't feel like a consensus, it felt like we were coming at the measure from different perspectives and we were using different scales to measure what, what we -- to decide what to vote.

MS. KHAN: Sorry, I was just going to say that some of the -- that happens a lot in a lot of different committees. So a lot of times once the measures have gone through public and member comment, the committee also has more information from other stakeholders to take into

consideration, and they'll re-vote on the measure.

So that is an option for you after you've considered the comments to re-vote on the measure if you would like, if the committee wants to. But it's not unique to this community at all, to this committee.

MS. MUNTHALI: And Adeela's very right. And I just wanted to add on to what she said is, you know, when you have these cross-cutting topic areas like health and well-being, care coordination, we see this sort of struggle. And this feedback you're giving us will help us. Perhaps some of these measures don't belong in this topic area. But you are the experts. You have varied perspectives. And that feedback you give us will be very helpful as we start to frame better the different topic areas that we have in our portfolio.

CO-CHAIR QASEEM: Do you think it's something that might be helpful to make sure that everyone is on the same page, to sort of have a half an hour of a crash course kind of presentation from

the NQF staff on what we are sort of -- for each of these categories what we are focusing on? I mean all of this is in the methods document that you guys have anyway.

But sometimes I -- I mean I have to agree with what Margaret just said, if you look at the overall voting, we have some significant concerns sometimes on each separate category, but then the bottom line vote is not really just, to me, at least scientifically, it's not making sense unless I'm missing something. And maybe it will help. But just I wanted to just hear from everyone. And we can discuss it at lunch as well. But thank you so much.

MEMBER HILL: Yes, I think as a newbie, knowing which must pass, you know, just being reminded of how that rubric, I think of it like a rubric if you're grading a test. You've got, you know, certain segments are worth more than others, and that kind of reminds you how your logic should flow.

CO-CHAIR QASEEM: And I think we can do

it like two or three slides and we can really make it short, to the point kind of presentation. We need to probably do it at the beginning of the meeting so everyone is on the same page.

MS. MUNTHALI: I think it's a good reminder for us. You know, this is the second time the committee has come together. If you remember in the first meeting we did go through that, but I think it is good because it is a year in between your measure reviews. And so I think this is good input for us, not just for this committee, but for other standing committees as well. We can go to lunch, I'm sorry, and be back at 1:15.

(Whereupon, the above-entitled matter went off the record at 12:52 p.m. and resumed at 1:21 p.m.)

MS. KHAN: Okay. So our last measure of today is 0280, Dehydration Admission Rate. We have the description up here for you, but what I wanted to just remind the Committee was why we're actually look at this again.

This measure was endorsed in 2007.

It's part of the AHRQ preventive quality indicators, and it's been publicly reported in Medicare fee for service physician feedback program. During our last review of this measure, there was a few concerns that were raised by the Committee.

The first one being the utility of the measure for continued quality improvement, specifically noting that there was a shift towards observation care, and emergency department management of dehydration, with related changes in billing practices.

The second was whether there changes in observation stays are a byproduct of a change in billing system, or improvement in care processes. Just as a reminder, the votes from our last review of this measure, they're actually listed here. Today we're actually only going to be voting on validity of this measure, and overall suitability for endorsement. So just those two criteria, because that's where the Committee landed with their decisions last time.

So at this time, actually I'll turn it over to the developers, to kind of present some of the additional analysis that they provided to us, and we can start the Q and A portion of the discussion.

MS. MUNTHALI: Oh, and Adeela, I just wanted to mention that Arjun is going to recuse himself from this measure, because of previous involvement with development.

MEMBER VENKATESH: Does that mean I can't talk at all, or just not vote?

(Laughter)

MS. MUNTHALI: No, you can't talk. But you can stay there. You can sit there, yes.

(Laughter)

MS. DAVIES: So are you ready for us? Okay. So I'm Sheryl Davies, and I'm a research associate at Stanford University, and we have the enhancement contract with the RQIs, I'm accompanied by Jonathan Shaw, who's an internist, family medicine, sorry. You can slap me later for that mistake -- family medicine and is our clinical

lead for the PQI enhancement work that we are conducting.

So today we'd like to discuss a little bit about the dehydration admission rate. This is a review. This is one of the PQIs, and these are meant to be a reflection of access to quality, community-based care.

In this case, the dehydration admissions are hypothesized to reflect prevention of dehydration through early treatment of dehydration, as well as through access to primary care, nurse advice lines, patient education and monitoring of particularly high risk patients, such as GI disease, elderly patients, and specific chronic conditions.

The indicator includes individuals with a principle diagnosis of dehydration. In our analyses, we found that that accounts for about 95 percent the numerator, as well as those with the principle diagnosis of acute renal failure, hypernatremia and gastroenteritis.

The latter criteria was added in 2009,

as a result of the clinical review of the indicator, where we had clinicians actually look at the different diagnoses. And that was, you know, really in response to this question about what if you just don't use the diagnosis dehydration, you know. What if people are using, you know, another diagnosis instead?

And so we've continued to monitor this issue over time, by monitoring, you know, what other diagnoses are accompanying the principle diagnosis of dehydration and also, you know, then looking at any of those diagnoses that are showing up also, you know, with dehydration, to see whether or not it should be added to -- as a principle diagnosis with a secondary diagnosis of dehydration to the specification of the indicator.

This indicator is tested using county level data, and the specified denominator is based on geographic populations or where the individuals live, and I wanted to really clarify that. Although this is used in CMS programs, that those indicators are adapted.

So we're asking the committee to evaluate this indicator based on the specified denominator of county level or area level or larger area level, so we can go up to a state or national. And we also wanted to know also that although traditionally access to care, you know, when many folks discuss it, they're focusing on access to primary care physicians to insurance. We actually have a conceptual model for these indicators that is much broader, and I think addresses some of the concerns that have been raised in the Committee earlier today.

We actually consider a very wide range of access to care. You know, aspects such as the ability to get an appointment at a time of day when it's feasible for you to actually go to that appointment, transportation to a physician's office. Community factors such as access to healthy environments, access to nurse advice lines, which an alternative means of obtaining health care.

In addition, you know, in the case of

dehydration, you know, that might expand to issues such as factors that reduce the impact of heat waves, such as air conditioning. So we think about this as a very broad access to care and community health, a very broad umbrella. So the Committee did actually review this indicator last year, and they raised some conceptual points, and those were already brought up in the introduction to this measure.

We just wanted to note that we provided an appendix to our application, which you should have all received, that highlighted the additional analyses that we completed. So the first analysis that we looked at was addressing this shift to observation care.

What we did is we actually used what we call the SEDD, or the State Emergency Department Database. Those are administrative data sets of emergency department encounters. Those include emergency department encounters that are identified as observation care, and those that are identified without an observation care flag.

We use a variety of means to actually identify. We look for evidence of an observation stay, not just, you know, there isn't one single variation that's used. It's an algorithm that's used to look for evidence of an observation stay.

We also looked at what's called the SASD database, which is actually outpatient care associated with acute care facilities. So these include, in fact, the database was originally put together as an ambulatory surgery database, but it's actually ambulatory services database, and includes other types of observation care that are independent of ambulatory surgery.

So we looked at also case within that database, that are flagged or have evidence of observation care. We looked at the trends over time, and we selected a variety of states that are known to have better observation data, and ambulatory care data, because you know, certainly it's not consistent to cross all states.

We ran it with a subset of eight states. We expanded to add a few more for just two years.

But we wanted to look over the three years, because of this question about incentives. So we actually wanted to map across the changes in observation, in the way that observation stays are reimbursed for CMS, and those changes are also, you know, outlined in the memo that you received.

And you know, what we found in that is certainly that we did find a decrease, as noted before, in inpatient stays. We also found an increase in observation stays. And so we found, you know, between 2006 and 2009, we found about a 30 percent increase in observation stays, about a 17 percent increase in 2009 to 2012.

You know, the inpatient stays decreased approximately about 25 percent across. It was a consistent trend over that time. ED stays without observation were flat for the first, the first time period, and then increased by about 11 percent.

We included this issue of ED stays without observation, because observation stays are actually an administrative tag. And so it's important to note that, you know, many times the

physician themselves does not actually choose to designate a stay as an observation stay. That's actually something that's done within the billing cycle, or at a different point in the care system.

So the thing that was really important to note about this particular analysis is that inpatient stays actually remain a pretty important portion of care. Although we see an increase and, you know, percentage-wise it sounds like it should be, but remember, this is the percent of the baseline.

So although we see an increase of outpatient stays, it certainly doesn't account for the decrease that we've seen over time, and the other thing that we don't know, that frankly, you know, we'd like to know but it's difficult to get at with these data, is how much of those -- that increase in observation stays and in ED stays or ED visits, really reflects a substitution effect, or whether these are also just simply a trend of increasing use of the ED, particularly as there have been shifts to -- from the ambulatory care

setting to shift individuals who might need rehydration, to an ED or an observation care setting, instead of receiving that rehydration within the physician's office.

So there's also pushes in that direction, to move care to a different -- to a different setting, instead of having that care occur in the physician's office. We did look to see, you know, whether this was consistent across counties. You know, the correlation between the care -- between the dehydration observation rate and the dehydration inpatient rate was moderate, suggesting that this relationship is not consistent across counties.

And again, we don't know why that's inconsistent, because that could also be because of differences in who is showing up. So it's not necessarily that the substitution effect is inconsistent, but there is, you know, some differences in the relationship between observation care and inpatient care across counties.

We also looked at, you know, who is remaining in the numerator. So the concern was raised if we see such a big decrease in numerator cases, what -- if we such a big decrease in the numerator cases, are the patients that are left, those are so complex that their hospitalization may not have been preventable in the first place.

So we took a look a little bit about, to look at the comorbidity burden of patients in the numerator, as well as a change in age, because age is certainly a high risk factor for dehydration. We looked at heart failure, diabetes, renal failure and cancer separately as comobidities that may be related to dehydration risk.

We also then looked simply at the number comorbidities, using the AHRQ Comorbidity Index. So you know, how many comorbidities were coded, and looked at that over time. We also looked at behavioral health comorbidities separately. We find very little evidence that the complexity, at least in this analysis, that the complexity is

changing over time. We do see some increases in the number of comorbidities listed. For medical comorbidities, we see an increase of 1.63 to 1.81.

However, we don't see that same increase in the specific comorbidities of interest, being heart failure, diabetes, renal failure and cancer, and we see consistency in the age of individuals within the numerator from 2008 to 2012 as well. So are there questions on the analysis that we've done?

MEMBER CARRILLO: Yes. I mean, did you look to see what proportion of the population is institutionalized? Because it's a fairly older cohort, 12 times more at 65 years of age are greater than the group 18 to 44. Is there -- can you identify those that are institutionalized, either at nursing homes or other kind of settings, where certain types of dehydration might be more common?

MS. DAVIES: Yes, so we don't -- so actually identifying individuals within administrative data that are institutionalized can be a tricky process. It sounds like it should be

easy, but it can be tricky, because of the way that individuals are admitted. We did not look specifically at those that have what we call of point of origin, from an institutionalized setting to see whether that has changed over time.

The long term care, you know, issue has been one that's come up consistently with this indicator, and our 2009 panel actually recommended this indicator for use in long-term care populations. However, you know, that's not the definition that we, you know, that we have today.

MEMBER CARRILLO: Right, because the -- we're looking, we're interested in ambulatory care sensitive condition as a PQI, but is this an institutionalized long-term care sensitive condition for a significant proportion of patients that are so overwhelmingly elderly, and some counties where there is more institutionalization of older patients, as opposed to other counties?

So I would be interested to just look at that as a measure. I mean I know my own experience in the ED and patients, seeing a lot of

older patients with, you know, sub, you know, sub-prime care in nursing homes coming in dehydrated, due to various different conditions.

MS. DAVIES: Yes. That was a measure that was recommended, and one that's kind of continued to be on our list. It would be different than what we have. But a measure with long-term care residents is the denominator.

DR. CHIANG: So the question that I noticed in reviewing this document is that it dovetails with what Emilio was saying, is that we know that dehydration tends to -- well that the people who are at risk tend to be either -- there may be cultural issues, language issues or mental illness issues. I didn't see that stratification in the report, and in the assessment. You said, you mentioned it I think very briefly, that I think that if this measure is actually really going to be validated, that somehow you need to incorporate that, the disparities part.

MS. DAVIES: Yes. So I think in the packet, you have the disparities table that looks

at that, but that doesn't necessarily get at, you know, exactly what you're speaking to. We agree that this -- and we're working on additional validity models for the PQIs, that look, although, you know, really capturing the impact of language or the impact.

You know, for these kinds of access to care measures, you know, it's very similar to the last discussion, where you know, these are kind of the initial screens and, you know, because our concept of access to care would certainly include issues of providing access, that it's appropriate for the individuals in that community, which would include culturally sensitive to care, and reaching out to those that are particularly vulnerable.

You know, we would argue that this is still a valid measure of access to care, that we do acknowledge that, you know, what means across different communities, maybe very different -- very similar to the way that, you know, what AMI mortality is reflecting may be very different across providers as well. So they're complex

measures, that's certainly true.

(Off mic comment)

MS. DAVIES: Yes, yes.

CO-CHAIR MCINERNY: As I remember from the last discussion, the concern was that as more and more of these patients were admitted to the observation and less to the actual inpatient service, that might give a false sense that things are getting better, because you're having less inpatient admissions calls. And in fact maybe it's not getting better. It's just that they're changing the coding. And I'm not clear, have you figured out how to handle that problem?

MS. DAVIES: So adding observation, you know, from our analyses, we feel that adding observation cases would not be good for this. The reason why we feel that way is twofold. The first of it is that observation data is very inconsistent across the U.S. So we would be adding a lot of noise into the measure that would be difficult to interpret.

The second reason is that not, you know,

we believe that not all those cases that are showing up in observation and in the ED are really substitute, substituting inpatient care, and so -- and inpatient care still seems, is you know, a large proportion of the care, and of individuals that are receiving care for dehydration. It's still a really important venue of care.

And so, you know, we maintain that, you know, looking at that is still very important. The third point with that, I think, is a little bit more of a conceptual one, and the Committee can decide, you know, kind of how this fits within the bottle.

But that's that, you know, some people would argue that receiving care in an observation setting, versus being admitted to the hospital, which has its own risks and expense associated with it, would be better access to care.

So there is a place in the conceptual model of this, to say that even though you're no longer seeing these patients through administrative, they still are not being admitted to stays within the hospital. We did look at, and

in your packet I believe that you see the inpatient observation care, and the stratification of the inpatient observation care. So we did look at that separately as well. So those patients are being seen in the hospital, but it's also a smaller proportion of those cases.

MEMBER SALIVE: So I'm happy with that explanation you just gave, and that it does address some of this validity concern that we had, and you know, so that really, the intensity of care of an admitted person with dehydration is higher, and the resource use is higher than observation.

You know, it's still sort of an option. But we're saying there's lots of dehydration that's not admitted, and it's treated in various ways. And so we're not focused on that. We are focused on the extreme end, where they do need to be admitted, and I think that has been addressed.

MEMBER MOLINE: But the question I think is also with the 48 hour rule, and how that's going to be changing, and in the extreme situations where someone might move out of the observation,

the 23 hour, within an ED, but is in the hospital for under 48 hours, that I believe is going to be coded in the observation, rather than as a typical admission.

I think that was one of the concerns as the coding changes, how is this going to capture the changes, because most -- some dehydration will need that 42 hours.

So they need more than 24, but maybe less 48, or they'll be if they pushed to, actually in some ways it's a two midnight rule actually. So maybe depending, or people will keep them for 49 hours, or the two midnights, so that they can count them as an inpatient. But that was some of the concern that we had last year I know.

MS. DAVIES: Yes, and the way that observation data, observation stays are captured in administrative data is a little bit complex, in that some of those cases that have evidence of observation stays will actually show up in the inpatient data, and then some of them will show up in a separate database.

So we acknowledge that this -- and you know, this is something that I think across all of the PQIs we have to be very, you know, we have to monitor, over time, consistently, and we do do that. We do monitor to see, you know, whether or not there are shifts within those, because we do have the data available.

CO-CHAIR MCINERNY: As mentioned earlier, the vote is on the validity of this measure. That would be one vote, and the other vote is whether to endorse or not, correct? So there's just two votes on this measure. The first vote is on validity, and we, I think we're ready, are we? Okay.

MS. ROBINSON-ECTOR: So voting for validity for Measures 0280 is now open, and for on the line, the Option 1 is high, Option 2 is moderate, Option 3 is low and Option 4 is insufficient.

And it looks like we're -- yes. Oh Ron, are you on the line? We're still waiting for your vote.

Okay. So we have all the votes, and voting is now closed. 4 voted high, 13 voted moderate, 1 voted low and 0 voted insufficient. So the measure passes on the criterion of validity.

CO-CHAIR MCINERNY: Good. Okay now, to endorse the measure, any other discussion?

(No response)

CO-CHAIR MCINERNY: Okay. Hearing none, shall we vote?

MS. ROBINSON-ECTOR: Just one second, and the vote for overall suitability for endorsement is now open, and for those on the call, Option 1 is yes and Option 2 is no.

Okay. It looks like all the votes are in, and voting is now closed.

CO-CHAIR MCINERNY: That's not right.

MS. ROBINSON-ECTOR: Yes, sorry. I'm going to clear this vote, and we have to revote. Okay voting for overall suitability for endorsement is open again.

Okay. Looks like all the votes are in, and voting is now closed. Okay. So 18 voted yes

and 0 voted no. So for Measure 0280, Dehydration Admission Rate, passes for suitability for recommendation for endorsement.

MS. KHAN: Thank you very much. I'll turn it over to Robyn at this point, to go over some of the work that we've been doing, the pneumococcal standard specifications.

DR. NISHIMI: Okay. We talked about this in the past, but I just wanted to remind the Committee that in response to a request from CMS, really back in 2007, that resulted in a 2008 report, NQF endorsed standardized specifications for both influenza vaccination and pneumococcal vaccinations. So the ones we're focused on here will be the pneumococcal vaccination measures. There are five pneumococcal measures in the portfolio right now. They pretty much follow the standardized specs.

They would have been up for renewal and evaluation by you all this year, but because of the changing guidelines, very recent changes, as recently as last September, we deferred those and

instead needed to make some changes to the standardized specs first, and so that's what we'll be discussing today.

The guidelines came out in three pieces as the slide indicates, immuno-compromised individuals 6 to 18, compromised individuals 19 to 64, and then there's guidance, guidelines around greater than or equal to 65.

The old specifications comported with the old guidelines, and it was really around the Pneumovax PPSV23. I'm just going to call it 23 from here on out. The new ACIP/CDC guidelines call for administration also in certain populations of the Prevnar 13. So I'm just going to start referring to these as 23 and 13.

What we have done is we reviewed the guidelines. We had a couple of calls with CDC. We had a call with the developers, and then we also had a work group that we worked with. So on the work group, as you can see, Mike Baer, Jacki Moline, Patricia McKane, Marcel Salive and Arjun.

They met by conference call to review

some proposed specifications. They had some questions about it that I'll go over, that required a little bit of follow-up with CDC, etcetera. So we'll cover that, and then obviously give the work group a chance to add any color that they wanted to.

The timing of the vaccine differs, depending on the population. So while we had one set of specifications before, this time what we're presenting to you now are three different specifications for each of the three subpopulations. We could have crafted specifications that -- a single set, but the denominator population would have been ugly, and the whole thing would have been a mess.

So for now, what we're recommending is a review of three different sets of specifications. What will happen is CDC is actually reconvening to try and address the issues of harmonization. That's not happening until June. So we didn't feel that we should be waiting around, because we can always combine the specifications, should CDC

reach alignment.

I apologize. This is a little bit hard to see, so I'm going to walk you through the three sets of specifications. Oh, and I guess there are handouts available to you as well. So if you look first at the denominator population, previously the denominator focused on individuals who were in long-term care facilities. That's been stricken out, and then each denominator is now separate across three populations.

So there's a denominator population, in this case for individuals 6 to 18 years who are immunocompromised. It lists the immunocompromised conditions, as specified by the guidelines. There are -- let me just go forward. The same change has been made for the 19 to 64, again just to the immunocompromised individuals, and then the last set of specifications has been changed to just limit it to the greater than or equal to 65 years of age.

So those are the changes to the denominator. Again, the principle change was that

individuals who may be in a long-term care facility, just a blanket individuals in a long-term care facility, is no longer part of the denominator. So if you are 62 years old, but you don't fall into one of the immunocompromised conditions, then you're outside of this -- no longer recommended to receive the schedule. Those are the changes to the denominator.

For the 18 to -- I'm sorry, the 6 to 18, the change now focuses on administration, if you've received the 23 already. So that's one population. If you've never had 23, it now calls for a sequencing of 13, then a certain period of time, and then 23. It also accounts for the timing between 13 and then 23, or 23 and then 13.

So those are all accounted for there. The numerator retains whether they have been offered it and declined. So it retains the patient choice option, and then it retains the medical contraindications. So if they've been assessed, they have one of the listed medical contraindications, then there's still -- the

provider is still given credit for those.

In the case of the 6 to 18, you can see the sequencing is eight weeks, and you will see for the 19 to 64, there's a one year lapse, and this is where the difference exists, and again, with the greater than or equal to 65 years. So that's the area that CDC is trying to reconcile. Are there any questions before I move on to the other questions, but just about the specifications?

(No response)

DR. NISHIMI: Okay. The work group had some questions in their discussion, and then there was also a question on one of the committee calls. One of the questions from the work group was because of the elimination of all long-term care benefits, I mean sorry beneficiaries, residents, whether CDC had looked at sort of a cost-benefit/cost-effectiveness analysis. So we queried CDC on that and, they had not. So there's no additional information on that.

The work group also asked about the time window issue relating to the interval, so that if

you received a vaccine at the end of the year, and your follow-up 23, let's say, didn't occur until the next year, how would the measure account for that?

This is generally considered an implementation issue, not at the level of specifications. So that the implementing entity would either have to extend the measurement period, or cut it off, you know, at November to account for the 30-day window or the 60-day window, however that went.

So it's not, generally not handled in the specifications, and we did not handle it in these specifications. And then finally there was a question about whether NQF's specifications differed from the guidelines, or have ever previously or now.

We did note that these guidelines and the original guidelines do call for certain pediatric populations in the 2 to 5 year range, a vaccination scheduled for them. But the committee then felt that apparently, and pediatricians here

can obviously speak to that much more clearly than I, but the timing, who gets it, when they get it is much more complex, and would begin to make the measure not feasible, essentially.

There were too many, you know, if this, then this type of constructs. So yes, this measure differs from the guidelines, apparently for the 2 to 5 year population. But it was done for feasibility purposes. The second way in which these specifications then and now differ is on the issue of the booster. The guidelines do provide a schedule for -- if 5 years or more have lapsed since the last administration of 23, the booster is recommended.

The work group felt that again, because of feasibility issues, data capture issues, trying to capture the booster after a five year interval, etcetera, wasn't really the point of the measure. The point is the primary vaccination. In reviewing the record of the original committee, they felt similarly.

So again, the specifications here

differ from the guidelines with regards to the booster. They don't include the booster. With that, I'll open it up to the members of the work group first, and see if there was anything they wanted to add about the discussion. Arjun, Patricia, Jacki, Marcel?

(No response)

DR. NISHIMI: Then I think the question before the Committee is -- I'm sorry, Eric.

(Off mic comment)

DR. NISHIMI: Oh, I'm sorry, yes.

MEMBER FRANCE: All of us have to.

DR. NISHIMI: Yes.

MEMBER FRANCE: I just wanted clarity on the issue about assessed and offered, but declined the vaccination as being in the numerator. Then you say, parentheses, computed and reported separately. So you have two different measurements. One is when you have the shared decision in the numerator and one without it.

DR. NISHIMI: The recommendation is that so that individuals or entities who want to

-- it's sort of a transparency thing. If you're a user, or let's say you're a purchaser and you want to see what the frequency is, separating it out into three different bins will tell you, you know, look. This person has 90 percent, you know, offered and received.

Is that really true, or are they just checking that off? So that's what that, you know, computed and reported separately. It's a recommendation that when, let's say CMS, requires reporting, that they're able to tease apart those three populations so that you could see potential gaming.

It wouldn't necessarily have to be, but that's how that construct came to be. It's the same for the influenza vaccination. Percent who refused, percent who said they got it somewhere else and percent who were actually vaccinated, and then medical contraindications.

CO-CHAIR MCINERNY: Other questions?

(No response)

DR. NISHIMI: So the question before

the Committee really is whether these -- if you recommend these specifications, go out to the membership for public comment. It's not a, you know, these are important, valid and scientific. It's are these ready to go out for public comment, and we're just looking for a show of hands.

So those in favor of recommending them for public comment, if you could have a show of hands?

(Show of hands)

DR. NISHIMI: Okay. Is anyone opposed?

(No response)

DR. NISHIMI: Okay.

MEMBER FRANCE: Can I clarify too?

DR. NISHIMI: Sure.

MEMBER FRANCE: I'm looking at my handouts, and I don't see the over 65. Is that something for later? Are there two or three of these?

DR. NISHIMI: There should be three.

(Off mic comments)

MEMBER FRANCE: I almost hesitate to ask it, but for the over 65, there were some questions of evidence, I think, that people came out with. But I don't know if the paper's been published from the randomized trial in Finland, I think it was, where they did the study for over 65s, showing its effect.

So I was just looking at these for the under 64s, and I'm curious about what it means to open it up for the over 65s. So I guess it's a question for the smaller group. The ACIP made a recommendation about PCV13 for persons over the age of 65. At the time, if you wanted to look at the paper to find the randomized trial that did it, it hadn't been published.

I don't know if it's now available, and then secondly there was a question. I heard someone say it was done in a country where PCV13 is not used routinely in children like it is in the United States. So the prevalence of invasive pneumococcal disease for people over 65 in our country and the efficacy of the vaccine over 65

might be different.

So those were just a couple of questions I had heard when the recommendations came out, and wondered if our subgroup is looking at those or considering that as part of the highest level quality of evidence for over 65 PCV13 endorsement.

DR. NISHIMI: We only looked at CDC's guidelines. It wasn't to go beyond. So if CDC -- we could query them to find out are they considering that, and are they doing anything about it. But we were guided by the CDC's work.

MEMBER FRANCE: So does our approval, is there a pass-through at the CDC for an NQF endorsement of one of their recommendations, or does it go through the same process as the others?

MS. KHAN: So we're actually -- once these specs go out for public and member comment, we're actually going to run them by CDC one more time. And then when you have a call to reconcile all the comments, that's when we'll kind of formalize and finalize these specifications. So we'll get all that information before.

DR. WILSON: Okay. I think we're done with pneumovax. Anything else?

MS. KHAN: So at this time, I'll turn it over to Elisa, who's going to -- oh wait, sorry. We have public and member comment. Operator, can you open the line for public and member comment please?

OPERATOR: Yes ma'am. At this time, if you'd like to make a comment, please press star and the number 1.

(No response)

OPERATOR: There are no public comments at this time.

MS. KHAN: Okay. So again, at this time, I'll turn it over to Elisa, who is going to be leading our gaps discussion.

MS. MUNTHALI: Thank you Adeela, and thank you Robyn. So we just wanted to spend a little bit of time today continuing our discussion from a year ago.

As you remember, last year we told you about the measures in the health and well-being

portfolio, which include about 60 odd measures across four primary domains, primary screening and prevention, those that measure modifiable social/environmental, and behavioral determinants of health, also those that look at the healthy lifestyle behaviors.

The ones that we are particularly concerned about and wish we had more of are those that measure the issues that matter outside the clinical care delivery system, so the other determinants of health. We talked about some of those today, the access measures, and I don't know if you could move ahead to the next slide.

I think there's a screenshot or a table of the gaps that this Committee identified, and also the Measures Applications Partnership Population Health Family of Measures Committee identified, and they were looking at a core set of measures across -- that can be applied across settings and across analytic --- analyses of care settings.

So there was some significant overlap

between what this Committee identified and what the MAP had identified. But I also wanted to share with you some overlap from a project that's ongoing on population health. We did inform you about this last year.

This is the Population Health Framework Project, and you probably have heard it also called the Community Action Guide. This is a project, it's a three-year project in which we're going out to communities to pressure test a field testing guide to improve population health in their communities.

So in the first year, we did an extensive environmental scan of what elements really are important for communities to come together. When we're defining communities, we're defining groups that have come together from the clinical care delivery system and public health system and are working a geopolitical area to improve the health of their populations.

So we did this environmental scan, and we came up with ten essential elements. Renee is

actually on that steering committee, and she's working with us very closely on that.

And those elements included asset mapping, making sure that all of the people in the groups knew what they had to offer to advance population health. It also included selecting appropriate metrics to measure improvement on population health journey, but also sustainability and scalability, a targeted communication plan as well.

So we came up with the first iteration of the guide in the first year, and then that -- at the end of the first year, beginning of the second year, which was fall of 2014, we put out a request for field testing groups.

We received about 43 applications from across the country, and we selected ten field testing groups that we're working with over the next two years. They are located in Spokane, Washington, from there to Trenton, New Jersey. Marsha went with me to Trenton. I just came back from Chicago at one of the field testing groups.

But one of the things we're trying to get from them is on the ground information on implementation. On the ground information on the measures that they want to see, the measures that they're using, the challenges that they have of data sources and availability of measures and data.

We have put together on what we're calling a measures chart, have collected about 600 plus measures from these ten field testing groups. Not a lot of them are NQF-endorsed as we expected, but we are trying to make sure that this is a tool that will help them. Not just us as people that work in measurement, but between each other as they're working in different areas of population health improvement.

We're also trying to see if there's an opportunity to align, you know, the information that we're getting. The important piece of this information too will feed into a group that we have as part of the government task lead. So CMS has funded this work, but we know that population health expands beyond just CMS to Transportation.

So we have put together a group of federal liaisons. So agencies across, you know, the federal government, that have a hand in population health, from Agriculture to Transportation, and CMMI is a part of that group. They're very interested in seeing what communities want, to perhaps, you know, inspire future measure development.

But what was interesting and what we learned from them as well, on some of the areas of opportunity, or where we hope to see measures in the future, were some of the areas that you identified. If you can pull up that list so I can see that. But they're also looking for those measures that assess the determinants of health outside the clinical care delivery system.

They're also looking at measures that assess care coordination, maybe at different levels of analyses than we have right now. But the number one issue is that they feel quite a bit of burden. There are a lot of measures out there, and it's really hard for them to navigate through

what's the best set of measures, or what measures can help them assess their progress.

So I wanted to tell you about that parallel work. I think it's very important, as we're talking about gaps, that we do have some information from folks that are actually implementing these measures, and I think it can -- I think it was encouraging to hear from them, that we're thinking along the same lines.

So I don't know if, Amir, if you wanted to add anything?

CO-CHAIR QASEEM: Yes. I mean I think that you really laid out the good background. Just caution more like, is it do you want more of a general discussion? Do you want Committee to make recommendations? What are you looking for?

MS. MUNTHALI: So you know, I would like us to talk about this a little further, and maybe not today, and what I was hoping is a number of other strategic issues came up today. I just wanted to touch on the gaps piece, ground it a little bit more. I know -- I think without

movement, we kind of need to --

We've had this list there. The MAP families has also had a similar list. So I think we're tracking. We're trying to get this list to those that develop measures and having some preliminary conversations. But I would like to talk about maybe some of the access issues that came up earlier today, and any other strategic issues.

So although the discussion piece said gaps, it is more of a strategic discussion for the Committee.

CO-CHAIR QASEEM: Great. Renee. Oh no, I was looking -- but were you guys involved together? I was looking for some --

MEMBER FRAZIER: Well, some feedback. So one of the things in joining this Committee, and I'm on the other committee, I see there's an intersect, but I'm not sure it's going to be easy to create it. I think it's a very different committee by the way, in terms of players that are around the table.

So three things that I thought about as

I think about this Committee. One is that this Committee is really what I would call the early adopter committee, because I think we are in a position that we can look at things a little differently than the traditional way of looking at measurement.

Because right now we are using more of a traditional model that we're comfortable with. But I think for us to probably really get to the level where I think the vision was that this Committee might get to, we may start have to -- may feel some discomfort.

I think for us to be successful as an early adopter type of model of health and wellness, because you know, nobody's really doing this, and I think NQF really stepped out when they said we're going to take this on.

I think being around this table and listening to the conversations, probably some of the richest conversation that I hear, trying to marry these concepts of health and wellness, within the context of this very traditional model of

looking at diagnosis and medical treatment. So I find it fascinating.

So I think the Population Health Committee is a very different group of people. It's a few folks that are around the medical side.

But it's a different -- it's a community type of individuals thinking very differently. If you look at their measures, they're very different from really the way we're thinking, but there's an intersect, and I think that's what we're trying to say.

So I don't know exactly how -- maybe we need to think about that we go out and seek developers. We've never thought about that. Maybe we actually say you know what? Maybe we need to seek some people and ask some developers could they help us develop this and come present to us, and we need to be pretty nice to them, by the way, if we do that.

We want to be very nice, and really encourage people that are willing to be out in front, not be as traditional as what we're

comfortable with, and maybe come up with a model where they test something for a year and come back and see whether or not it's workable, as opposed to having all the evidence, which we're so comfortable with. That's the model of NQF.

So that's kind of my thought process. As I said on both of these two committees, I can see the intersection, but I can't figure out the mechanics yet, of how to get us to actually approving health and wellness measures.

Because right now, we're kind of still dancing around whether we're really approving health and wellness. My observation is the closest thing we've gotten to really approving health and wellness is the dental measures actually, and they kind of learned something from when they came to us last time. We were pretty tough on them.

This time, they kind of pleased us a little bit, because they went back a little bit into the medical model and made us more comfortable. I don't know if you guys realized that. That's what

they did, and probably staff told them how to do it. They were smart. So I think -- I think the dental piece is actually the closest thing that I've seen personally to more of the preventive side, as opposed to the typical medical stuff that we're all used to in our work.

So I mean try to marry these two conversations is going to take -- and the MAPs is going to take a little work. But we may have to think differently how we encourage developers, try to, you know, groom some developers that are willing to come in front of us with some concepts and ideas that aren't typical to what we've seen in the past.

That's kind of my thinking. This committee is the innovator. This committee is the committee to be out in front. That's my thinking of why NQF did this.

MEMBER CARRILLO: I think it's fascinating. I just took a quick look at the 600, you know, measures, which is a lot of apples and oranges and berries and nuts and you name it. And

so -- so I mean the first thing that I'd be thinking is: Well, what categories?

Do we have like social determinant categories, causal determinant categories, different types of access barrier categories, to kind of like get away from like Census, Transportation, this-that, to just more categorical framing. In the literature, there's a few models out there of how to categorize these things. So I think it's great this is coming from the field. It's terrific.

CO-CHAIR MCINERNY: Yes. I think this is terrific, and I applaud NQF and your group for working on this. You know, as everyone probably already heard, really 80 percent of health is really social determinants of health, not what -- medicine can only affect about 20 percent.

So that's a huge problem, and that's what you're addressing, and we're learning more and more from epigenetics that it's the environment.

By the environment, we mean not only toxins but also stressors, anxiety, parental and

children, parental problems and so forth, that can lead to epigenetic changes and ACE, the adverse childhood experiences and toxic stress and all of that. So that's very, very important.

I like that you -- I saw somewhere that you're involving the justice systems and the educational system. I think that's very important. Unfortunately in the past, we've sort of been too narrow in our focus, and some of the changes that perhaps take place, either in medicine or in the environment -- general environment of health -- affect how well kids to, from my point of view, in the educational system and in the juvenile justice system.

And then one last comment. I'm aware of some very strong activity in this area at Nationwide Children's Hospital in Columbus. They are really, I think, one of the leaders in area of trying to look at population health. They've had many, many years of experience with a large number of Medicaid patients throughout the Ohio region and have learned a lot, and are moving into the whole

population health area, to see how they can improve health at that level.

So if you want to bend somebody's ear, they may be good folks to speak with.

(Off mic comment)

FEMALE PARTICIPANT: Use your microphone, please.

MEMBER FRAZIER: I am familiar with their work, because I think they work very closely with IHI. So I am familiar with the work that they're doing. It's a good idea.

MEMBER BIALEK: Yes, excuse me. This is quite interesting work, and I'm wondering how it relates to some of the work for, you know, I guess 15 years or so of community health indicators, like the MAP tool from the National Association of County Health Officials, community health status indicators, county health rankings and a variety of other instruments that have really -- or efforts that have looked across measures at the community level to try to figure out what might be the most important to measure, to track, etcetera.

So how do those, or do those relate to this effort at all?

MEMBER FRAZIER: On the Population Health Committee, we actually bought in a consultant and Diane, who is well known in her work with AHRQ, and she has tried to help us think through the intersection of long-standing measures that have been in the marketplace, public health measures.

Of course, the county health rankings are actually young. Honestly, they're young and I think the experience with those is that they're not able to really direct communities enough to execute on specific interventions. They're very good at providing, I would say, the opportunity where you should look.

But when you get to the area of intervention, and we're learning this with the communities that we're talking to, there needs to be something better that can be used to track improvement. So I think there's a lot of -- there is an intersection. There's still a lot of work

to figure out how to align that intersection with work that communities are doing, so they can see improvement.

So when you think about 600 measures, this is overwhelming. So I don't think we've figured that answer out yet. But we have been working with a couple of people, consultant types who know this work, that can really help think through a process of trying to decide how to best execute one, coming up with ways to use these measures consistently across.

That's the one thing we went through with AHRQ. I'm looking at Marsha. One of the things we learned with AHRQ in the work with Robert Wood Johnson, is the challenge of working across 16 communities doing multiple measures, and we spent a lot of time trying to line up measures and who was doing what, and it was very challenging, because communities have very individual thinking about what they want to measure, how the data is available, what their understanding is, how the data can be translated.

So it's very difficult, very difficult. I think it's attainable. I think we're on the right path.

MEMBER SPANGLER: I know the stuff Renee's mentioning, and I think -- when I think of some of these gaps, not on the access subject, because I do think that's a huge area. But one is that we -- and it came up in the discussion of social determinants of health within this group last time.

And it's as you start thinking about these real indicators of health and well-being, you have to leave, what Renee referred to as the biomedical model of things that we tend to measure. So either we can measure actions or events that occur in the health care system, or sometimes we say the absence of an event is a good health or well-being, right. So not hospitalized is good health.

But if you think on the context of the patients we see and the people in the health care system and people in communities, it's often, and I'm thinking really the context of the shift I just

worked this past weekend. For a lot of older adults, the outcome of interest is not not hospitalization; it is remaining community-dwelling.

So it's really thinking about how do you think of these outcomes that we have historically not allowed to be attributed to health programs or health things around, like how effective is a health care system in ensuring that older adults are community-dwelling, something along those lines.

Or the flip side of that that comes, how do you start thinking about health outcomes being attributed to whether otherwise historically siloed offer social services. So a huge challenge we have is around homeless patients, health care utilization and housing.

So what if a housing department was evaluated based on health care utilization and health status, as opposed to, you know, what it currently is, which is just the ability to reside in housing that's created for the homeless and

things like that.

So I think we have got to figure out ways to break out of these, you know, separation silos of the biomedical world and the social service world, and start thinking about where those two things intersect. The measurement has to go there, and where it gets really uncomfortable and challenging is around quickly accountability stuff comes up, right?

So in the same way you'll hear health care providers say well, I can't be in charge of all that stuff that happens in terms of social determinants; that stuff's not attributable to me. The same thing happens, right, when you talk to those who are in the trenches with a variety of other social determinants of health about the health outcomes.

So we've got to figure out ways to think about how measures create an infrastructure and support, for those two to start working together.

MEMBER HILL: I would like to see us have some dialogue about how to cross-pollinate

these two groups, so that through exposure, we could begin to develop some dialogue, maybe either a subset of our group participating on that one, or that there's some kind of meeting schedule where we can begin to set an achievable goal of having some dialogue in some category of mutual interest.

MS. MUNTHALI: Yes. I think that's a great idea. Renee being on this committee is by design, and we're trying to make sure that there are linkages not just in the committee, but in staff. I'm on that project as well. But I think it's a great idea.

We'll talk with CMS to see, because what we're seeing is this list, it keeps growing, and we need to find some way to bring some traction. And also the other project is also predicated on our formal work. Ron was on that project and Jason was on that project as well and Mike.

And that work was based on foundational work that Steve Teutsch and Dawn Jacobson put together, and it was really looking at that intersect, and many of you have said it, between

the public health system and the clinical care delivery system, and that's the foundation of the other project as well. So we're looking at the same thing, but we're trying to maximize the alignment between the two projects.

MEMBER BIALEK: You know Renee, you used the term "early adopter," and you know, as I look at this list and think about the discussions we've had, NQF has been set up to have measures presented and endorse the measures, and there really is no incubator, if you will, for population health measures to do this in a way that's substantive, scientific.

It strikes me that that's the direction we need to be going, okay. Yes.

DR. WILSON: Yes. I guess we were smiling a big. NQF in the past couple of months has -- our Board of Directors has approved us moving forward with an incubator, and I'll explain this briefly. The concept was measure developers are often working in silos. They spend a lot of time specifying measures, only to go out and go oops,

no data, you know.

An editorial comment. I think data is a huge sticking point with measure development. So what the board approved is NQF is currently talking to a bunch of different entities who might partner in this idea of an incubator, and we would bring together measure developers, folks with data, big goo-gobs of data hanging around, and bring them together to one, look at gaps in measures and perhaps get to those measures a little more expeditiously.

So NQF would not be the measure developer. We're not going into that business. That's not what we do. But we would facilitate the partnerships and the environment, where people could come together to work on some of these gaps.

Now obviously there needs to be funding there, so that's another one of the issues. But there are a number of people, there are a number of organizations and people who are thinking about developing measures, but maybe it's just a little daunting. Hopefully, this would facilitate it.

So where we are right now is we're talking to a number of potential partners. We hope to have some partnerships solidified before too long, and hopefully this will give us an opportunity to do just that.

MR. VALDEZ: Well, just in follow-up, that's pretty exciting, and I think that's really wonderful. But it reinforces my concerns, and that is that if we're going to move in that way, if NQF is moving that way, then we also need to rethink how we evaluate measures, particularly early developed measures, where evidence and the kinds of structured protocols that you've set up, based on really a model around more traditional quality of care measurement structures, doesn't really make sense.

So it really requires a willingness and an acceptance to completely develop a different way of thinking about it, and to accept the kinds of risks that come with creating new measures that are untested, and perhaps have limited or no evidence, other than it makes logical sense.

DR. WILSON: You raise an excellent point, and we absolutely have to go there, and actually we're already starting to go there in some capacities.

A couple of examples that come to mind is through the Measure Applications Partnership, we get measures under development that are in a slightly different state than a full-blown, fully developed measure.

In the e-measure world, we have issues with testing of e-measures, given the state of the vendors and the data that are available, the different systems that are available for testing. So this is, I think, a logical extension of that incubator process, is that we are going to have to look at what the evidence should be when we work with measures that are in an earlier state.

And Elisa, if you have any other comments that you want to add, please feel free.

MS. MUNTHALI: Just to add on to what Marsha said, we are in the process of rethinking a lot at NQF, and one of the things we're rethinking

is the way you just went about reviewing maintenance measures and newly-submitted measures.

I heard during the break some were like, you know, why are we revisiting these measures? They've already been tested. The testing hasn't changed, the evidence base hasn't changed. Why do we go through the same process? We started asking ourselves why as well. Developers were, and CMS was as well.

So we're rethinking the way we look at maintenance. We will not be looking at, if this proposal goes forward and we've gotten initial, you know, directional support from our Consensus Standards Approval Committee, which is a subset of our Board, to move forward with a plan to only look at maintenance measures if we want to get the information that really matters to folks, about implementation and use and usability.

But unless, you know, the evidence base has changed or the testing hasn't changed, we're not going to reassess that. It will be the new

measures will go through the process as it does right now against the four criteria to be evaluated. But we will look at those two measures differently.

So we're hearing you. It's taking us a while to, you know, do all of these things. We've been quite busy. But we know that to get the measures we want here, we also may need to readjust the way we think about approaching development and endorsing measures.

MEMBER McKANE: I'm glad to hear that, and we've talked about this before, about the difficulty depending on the type of measure, to have a structure. The way we evaluate it, the Board criteria won't change. But, you know, I guess I was wondering if there's going to be some change to the framework or even to the criteria themselves, particularly where we're talking about different types of measures.

For some of these measures, this works really nicely. With others, it was a struggle, and quite frankly I come out on the algorithm and I'm

thinking well, this is what I think it is, but based on all the evidence, it's telling me to go down here. Are you working on that too?

MS. MUNTHALI: We're not quite working on it, but that doesn't mean we won't work on it. Renee is very right. Population health, health and well-being, we are early adapters in the NQF world. This is just the second endorsement and maintenance project that we've had, and for those that were on the first one, they know how difficult it was.

But one of the things we did is look at the evaluation criteria, and the committee, you know, deemed by and large, you know, with exception to nomenclature, that these criteria should be applied to population-based measures. Now that doesn't mean we can't revisit it, now having had at least another project of experience. So that's something we've been thinking about.

MEMBER FRAZIER: So that brings me to the question as to what actually happens to a measure. So the Measure 1385, we did not come to

consensus. It was a maintenance measure. So what happens? What's the next step? Does it just fall off the list and go away or -- so what happens with that?

MS. KHAN: 1385 was that developmental screening?

MEMBER FRAZIER: Yes.

MS. KHAN: So that measure actually didn't pass on reliability.

MEMBER FRAZIER: Right, correct.

MS. KHAN: So it's not going to move forward in our process.

MEMBER FRAZIER: So but it had been in the past. It was approved in 2011?

MS. KHAN: Yes. It was approved in 2011, and I believe -- was it a trial use measure?

MS. MUNTHALI: Not trial use. It didn't have testing, so it was time-limited.

MS. KHAN: Time-limited.

MEMBER FRAZIER: It was a time-limited measure?

MS. MUNTHALI: Yes, it was

time-limited.

MS. KHAN: Yes.

MEMBER FRAZIER: Okay.

MS. MUNTHALI: There is an opportunity, as part of our consensus development process, for the developer to bring a reconsideration request. They can do that during our comment period. So that that is there, and I know we talked about the value of some measures.

They may not meet all of the NQF criteria, but you feel uncomfortable saying no, we don't want this anymore, and that's why we asked about the feedback to give to developers, because we do see it as an opportunity to improve. But there may be some other channel. But yes, it is no longer endorsed as it stands right now.

MEMBER FRAZIER: So it made me think about depression screening. You know, ten years ago, primary care doctors kicked and screamed and said there was no way I'm going to do depression screening, and now today that's the standard.

So when I think about this measure, I

thought about wow, here's something out in front, that I'm hoping the developer does come back and is more prepared to articulate maybe the argument of doing this, as a continuing way of looking at what's going to be needed in ten years. We need to be testing it now.

So that was the same way with the depression screening. It was never included in primary care. It just was not done. So I really believe that's a measure that probably will come back. I hope so.

CO-CHAIR QASEEM: Except the difference between depression and this one is depression there was evidence that was brewing, right? I mean eventually once we have evidence, I think we should have a performance measure, and I think that was the concern --

MEMBER FRAZIER: And I think the incubator concept could help somebody like this be a little more sophisticated in how to bring something like that, because it really interests me, because I do so much work around family and

parent engagement, and to start measuring engagement of parents and families and caregivers on how to better navigate wellness and care for their constituency or their loved one.

We really have to figure out this whole thing around family and parent, you know, all this caregiver engagement. We're going to need it. We're really going to need it, and we're going to have to be more health literate to do it. So the way to get there is to give us some responsibility to be more activated to engage with the system in a measurable way.

That's why I was so impressed with what was on the table. So I'm hoping we'll figure out how to bring those types of engagement opportunities back.

(Off mic comments)

CO-CHAIR MCINERNY: Thanks everyone.

MS. KHAN: So I will turn it over to Kaitlynn for our next steps.

MS. ROBINSON-ECTOR: Okay. Can I see the slide?

CO-CHAIR MCINERNY: Next steps.

MS. ROBINSON-ECTOR: Thank you. Okay. So the next steps moving forward in the health and well-being projects was the post -- yes. So we did have a hold for the post in-person meeting call, but since we got through everything today, that meeting is now cancelled. So more time back.

(Laughter)

MS. ROBINSON-ECTOR: So the next official meeting will be the post comment review call, which will be taking place July 16th, 2015 from 1:00 p.m. to 3:30, and after we have that call, we will move into member vote, and that will take place on July 29th. So a draft of the report will be posted with that as well, and it will also include any comments the Committee has to comments made during the comment period.

Then after the member vote, we'll move to CSAC review and approval, and that will be taking place in September. After CSAC, the measures will go to the Executive Committee, and that will be taking place sometime in October. After the

Executive Committee, appeals will be taking place in October as well.

MS. KHAN: Thanks Kaitlynn.

CO-CHAIR QASEEM: And you will email all these dates.

MS. ROBINSON-ECTOR: Yes, and the Committee will be getting updates, also to notify you when the draft report will be posted for all these phases. But then also just to keep you updated on the dates, like the commenting dates, the voting period and also CSAC dates and appeals.

CO-CHAIR QASEEM: And I was having a sidebar over here, but can you just tell us, where does MAP fits into all this?

MS. ROBINSON-ECTOR: MAP?

CO-CHAIR QASEEM: Yes.

MS. ROBINSON-ECTOR: So MAP discussion actually will start -- in August they actually start. We start ramping up in August, but actual MAP meetings take place in December, and as of right now, this process is separate from that. But we are trying to have more overlap, by having some of

our standing committee members join MAP work groups as well. But was there a particular --

MS. MUNTHALI: What Amir was asking me earlier is about feedback loops, and making sure the information. That's something we've talked about internally we're working on. We just merged our two departments, the Strategic Partnerships Department, which houses the Measures Application Partnership, and the former Performance Measurement, part of now Quality Measurement.

So we merged those about six months ago. So we're talking about how we can better align our work, you know, internally. So hopefully we'll see more feedback loops. But both processes are very independent of each other. The MAP is making recommendations to the federal government for measures in federal programs.

And so, you know, while that's an important piece of our criteria, we want to make those separate but informative. So we're trying to figure out how to do that.

CO-CHAIR QASEEM: And the only reason

I was bringing it up is because I am on MAP, and I feel like that they're still independent a little bit, and I think we need to close a loop a little.

MEMBER FRANCE: Just to remind us, we at our last meeting a year ago pulled little pieces of paper that said whether we were serving two or three years. So have we completed 12 months as of today, and so is the second year through April or through the end of December? Where in the calendar will we be?

MS. KHAN: I believe that it's two years after the seating of the Committee. So will have just -- we finished one year. So next February, I think, we'll be at two years. But we'll follow up with everyone about those logistics and who needs to reapply, if you want to reapply.

CO-CHAIR MCINERNY: So on behalf of the co-chairs, I would like to thank everyone for their very rich and generous discussion today, and for their donation of their expertise and time into considering the measures carefully and giving information to the rest of the Committee, so that

we could make our decisions.

I also want to thank very much the staff for organizing a very complex process, and making it very user friendly as they way for us, so that we are able to, I think, have good discussion and come to some good conclusions.

(Applause)

MS. MUNTHALI: Sorry. On behalf -- thank you. And on behalf of the staff, we just want to thank Amir and Tom for your leadership on the Committee, and thank all of you. We really thank you for the time you put into this process. We know it's very long and you travel far, many of you. So we wish you a safe journey back home. Thank you so much.

OPERATOR: Thank you.

CO-CHAIR MCINERNY: Thank you.

(Whereupon, the above-entitled matter went off the record at 2:46 p.m.)