

Health and Well-Being Standing Committee: In-Person Meeting Summary September 12-13, 2016

The Health and Well-Being Standing Committee met in-person on September 12-13, 2016, at the NQF offices in Washington, D.C. to evaluate 24 measures. Additionally, the Committee provided feedback and guidance on the role of the standing committee in overseeing the NQF Health and Well-Being portfolio of measures.

- **Introductions and Disclosures of Interest**
 - The Committee co-chairs opened the meeting with welcoming remarks and staff introduced the NQF Health and Well-Being project team and support staff.
 - NQF's General Counsel reviewed NQF's Conflict of Interest Policy while each Committee member introduced themselves and disclosed any potential conflicts of interest.
- **Project Introduction and Portfolio Overview**
 - Staff reviewed:
 - The current Health and Well Being portfolio of measures.
 - The updates to the measure evaluation process.
 - The role of the Standing Committee in overseeing the NQF portfolio of measures, providing strategic direction for future measure development, and increasing developer involvement in measure evaluation.
 - Ground rules for Committee discussion and interaction, as well as the process for presenting and discussing measures at the meeting and achieving consensus on voting.
 - An overview of the voting criteria and instructions on using the voting software.
- **Overview of eMeasure Evaluation**
 - NQF Staff provided an overview of the evaluation criteria and process for eMeasures, including measures eligible for Trial Use, and fully-specified measures, which included legacy measures and hybrid measures.
- **Measure Evaluation**
 - **Key:** H – High; M – Medium; L – Low; I – Insufficient; IE – Insufficient Evidence with Exception; Y – Yes; N – No
 - **0032: Cervical Cancer Screening (CCS) (National Committee for Quality Assurance)**
 - Developer Representatives: Lindsay Roth, Sepheen Byron
 - Votes
 - Evidence – carried over vote from previous maintenance review.
 - Opportunity for Improvement – **H-1; M-11; L-1; I-0**
 - Reliability – carried over vote from previous maintenance review.
 - Validity – **M-13; L-0; I-0**
 - Feasibility – **H-4; M-9; L-0; I-0**
 - Usability and Use – **H-0; M-11; L-2; I-0**
 - Overall Recommendation – **Y-13; N-0**
 - Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee's deliberations will be compiled and provided in the draft report.

- **0038: Childhood Immunization Status (CIS) (National Committee for Quality Assurance)**
 - Developer Representatives: Mary Barton, Sepheen Byron
 - Votes
 - Evidence – carried over vote from previous maintenance review.
 - Opportunity for Improvement – **H-11; M-2; L-0; I-0**
 - Composite (1d.) – **H-3; M-4; L-4; I-1 (Consensus not reached)**
 - Reliability – carried over vote from previous maintenance review.
 - Validity – carried over vote from previous maintenance review.
 - Composite (2d.) – **H-3; M-7; L-3; I-0**
 - Feasibility – **H-4; M-9; L-0; I-0**
 - Usability and Use – **H-12; M-1; L-0; I-0**
 - Overall Recommendation – **NA**
 - The Standing Committee failed to reach consensus on this measure; specifically, the Committee did not reach consensus on 1d. the quality construct and rationale. It will be designated as “no consensus reached” and put out for public and member comment to gather input from the field before proceeding. The Committee will discuss the measure again on their Post-Comment call held on December 6, 2016. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **0039: Flu Vaccinations for Adults Ages 18 and Older (National Committee for Quality Assurance)**
 - Developer Representatives: Mary Barton, Jenna Williams-Bader
 - Votes
 - Evidence – **H-11; M-1; L-1; I-0**
 - Opportunity for Improvement – **H-11; M-1; L-0; I-0**
 - Reliability – carried over previous vote.
 - Validity – **H-6; M-7; L-0; I-0**
 - Feasibility – **H-6; M-7; L-0; I-0**
 - Usability and Use – **H-6; M-7; L-0; I-0**
 - Overall Recommendation – **Y-12; N-1**
 - Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **0226: Influenza Immunization in the ESRD Population (Facility Level) (Kidney Care Quality Alliance)**
 - Developer Representatives: Lisa McGonigal
 - Votes
 - Evidence – carried over vote from previous maintenance review.
 - Opportunity for Improvement – **H-5; M-7; L-1; I-0**
 - Reliability – **H-1; M-11; L-1; I-1**
 - Validity – **H-0; M-13; L-1; I-0**
 - Feasibility – **H-6; M-8; L-0; I-0**
 - Usability and Use – **H-9; M-5; L-0; I-0**
 - Overall Recommendation – **Y-13; N-1**

- Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
 - **0431: Influenza Vaccination Coverage Among Healthcare Personnel (Centers for Disease Control and Prevention)**
 - Developer Representatives: Megan Lindley
 - Votes
 - Evidence – **H-5; M-9; L-0; I-0**
 - Opportunity for Improvement – **H-3; M-11; L-0; I-0**
 - Reliability – **H-1; M-13; L-0; I-0**
 - Validity – **H-3; M-11; L-0; I-0**
 - Feasibility – **H-2; M-12; L-0; I-0**
 - Usability and Use – **H-11; M-3; L-0; I-0**
 - Overall Recommendation – **Y-14; N-0**
 - Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
 - **0041: Preventive Care and Screening: Influenza Immunization (PCPI Foundation)**
 - Developer Representatives: Elvia Chavarria, Yvette Apura, Diedra Gray, Steven Purcell
 - Votes
 - Evidence – **H-2; M-11; L-0; I-0**
 - Opportunity for Improvement – **H-11; M-3; L-0; I-0**
 - Reliability – **H-6; M-8; L-0; I-0**
 - Validity – **M-13; L-1; I-0**
 - Feasibility – **H-10; M-4; L-0; I-0**
 - Usability and Use – **H-11; M-3; L-0; I-0**
 - Overall Recommendation – **Y-14; N-0**
 - Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
 - **3070: Preventive Care and Screening: Influenza Immunization (eMeasure) (PCPI Foundation)**
 - Developer Representatives: Elvia Chavarria, Yvette Apura, Diedra Gray, Steven Purcell
 - Votes
 - Evidence – carried over previous vote.
 - Opportunity for Improvement – **H-10; M-4; L-0; I-0**
 - Reliability – **H-8; M-5; L-0; I-0**
 - Validity – **M-11; L-2; I-0**
 - Feasibility – **H-2; M-10; L-1; I-0**
 - Usability and Use – **H-3; M-11; L-0; I-0**
 - Overall Recommendation – **Y-14; N-0**

- Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **0680: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccination (short stay) (Centers for Medicare and Medicaid Services)**
 - Developer Representatives: Colene Byrne, Laura Smith, Dan Barch
 - Votes
 - Evidence – carried over vote from previous maintenance review.
 - Opportunity for Improvement – **H-11; M-3; L-0; I-0**
 - Reliability – **H-1; M-6; L-5; I-2 (Consensus not reached)**
 - Validity – **H-1; M-6; L-4; I-3 (Consensus not reached)**
 - Feasibility – **H-13; M-1; L-0; I-0**
 - Usability and Use – **H-12; M-2; L-0; I-0**
 - Overall Recommendation – **NA**
 - The Standing Committee failed to reach consensus on this measure; specifically the Committee did not reach consensus on Reliability and Validity. It will be designated as “no consensus reached” and put out for public and member comment to gather input from the field before proceeding. The Committee will discuss the measure again on their Post-Comment call held on December 6, 2016. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **0681: Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (long stay) (Centers for Medicare and Medicaid Services)**
 - Developer Representatives: Amy Helburn, Laura Smith
 - Votes
 - Evidence – carried over vote from previous maintenance review.
 - Opportunity for Improvement – **H-1; M-13; L-0; I-0**
 - Reliability – **H-1; M-9; L-2; I-2**
 - Validity – **H-1; M-13; L-0; I-0**
 - Feasibility – **H-12; M-2; L-0; I-0**
 - Usability and Use – **H-11; M-3; L-0; I-0**
 - Overall Recommendation – **Y-13; N-1**
 - Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **1659: Influenza Immunization (Centers for Medicare and Medicaid Services)**
 - Developer Representatives: Bob Dickerson
 - Votes
 - Evidence – carried over vote from previous maintenance review.
 - Opportunity for Improvement – First vote: **H-0; M-7; L-7; I-0**; Second Vote: **H-0; M-5; L-9; I-0 (Consideration for Inactive Endorsement with Reserve Status)**
 - Reliability – **H-7; M-2; L-4; I-1**
 - Validity – **M-11; L-3; I-0**
 - Feasibility – **H-2; M-8; L-4; I-0**

- Usability and Use **H-9; M-5; L-0; I-0**
 - Potential for Reserve Status – **Y-14; N-0**
- Overall, the Committee recommended this measure for Inactive Endorsement with Reserve Status. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3059: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk (eMeasure) (PCPI Foundation)**
 - Developer Representatives: John Ward, Elizabeth Bostrom, Yvette Apura
 - Votes
 - Evidence – **H-4; M-8; L-1; I-0**
 - Opportunity for Improvement – **H-3, M-7, L-3, I-0**
 - Scientific Acceptability – **H-4; M-8; L-1; I-0**
 - Feasibility **H-1; M-10; L-2; I-0**
 - Usability and Use **H-1; M-8; L-3; I-1**
 - Recommendation for Trial Use – **Y-11; N-2**
 - Overall, the Committee recommended this measure for endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3060: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users (eMeasure) (PCPI Foundation)**
 - Developer Representatives: John Ward, Beth Bostrom, Yvette Apura
 - Votes
 - Evidence – **H-0; M-8; L-2; I-1**
 - Opportunity for Improvement – **H-2; M-8; L-0; I-2**
 - Scientific Acceptability – **H-0; M-10; L-3; I-0**
 - Feasibility – **H-0; M-11; L-2; I-0**
 - Usability and Use – **H-0; M-11; L-2; I-0**
 - Recommendation for Trial Use – **Y-11; N-2**
 - Overall, the Committee approved this measure for trial use. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3061: Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection (eMeasure) (PCPI Foundation)**
 - Developer Representatives: John Ward, Beth Bostrom, Yvette Apura
 - Votes
 - Evidence – **H-7; M-4; L-2; I-0**
 - Opportunity for Improvement – **H-7; M-5; L-1; I-0**
 - Scientific Acceptability – **H-2; M-9; L-2; I-0**
 - Feasibility – **H-2; M-10; L-1; I-0**
 - Usability and Use – **H-1; M-10; L-2; I-0**
 - Recommendation for Trial Use – **Y-11; N-2**
 - Overall, the Committee approved this measure for trial use. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3071: Follow-up Referral after Positive Developmental Screen (Northwestern University)**
 - Developer Representatives: Ramesh Sachdeva
 - Votes

- Evidence – **H-0; M-2; L-2; I-11**
- Insufficient Evidence with Exception – **Y-10; N-5**
- Opportunity for Improvement – **H-6; M-7; L-2; I-0**
- Reliability – **H-0; M-6; L-7; I-2 (Consensus not reached)**
- Validity – **M-2; L-5; I-7**
- Overall Recommendation – **NA**
- The Standing Committee did not recommend the measure for endorsement; specifically, the measure did not pass Validity. It will be designated as “no consensus reached” and put out for public and member comment to gather input from the field before proceeding. The Committee will discuss the measure again on their Post-Comment call held on December 6, 2016. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **0279: Bacterial Pneumonia Admission Rate (PQI 11) changed to Community Acquired Pneumonia Admission Rate (Agency for Healthcare Research and Quality)**
 - Developer Representatives: Carol Stocks, Cheryl Davies
 - Votes
 - Evidence – did not vote on this criterion. (Measure transferred from current Pulmonary and Critical Care Committee)
 - Opportunity for Improvement – **H-5; M-9; L-0; I-0**
 - Reliability – **H-7; M-7; L-0; I-0**
 - Validity – **M-9; L-5; I-0**
 - Feasibility – **H-11; M-2; L-1; I-0**
 - Usability and Use – **H-3; M-8; L-3; I-0**
 - Overall Recommendation – **Y-12; N-2**
 - Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3067: Human Immunization Virus (HIV) Infection Screening (Centers for Disease Control and Prevention)**
 - Developer Representatives: Abigail Viall
 - Votes
 - Evidence – **H-10; M-5; L-0; I-0**
 - Opportunity for Improvement – **H-12; M-3; L-0; I-0**
 - Reliability – **H-0; M-5; L-5; I-5**
 - Overall Recommendation – **NA**
 - Overall, the Committee did not recommend this measure for endorsement; specifically, the measure did not pass Reliability. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3086: Population Level HIV Viral Load Suppression (Centers for Disease Control and Prevention)**
 - Developer Representatives: Abigail Viall, Irene Hall
 - Votes
 - Evidence – **H-5; M-10; L-0; I-0**
 - Opportunity for Improvement – **H-10; M-5; L-0; I-0**

- Reliability – **H-0; M-7; L-5; I-3 (Consensus not reached)**
- Validity – **H-0; M-9; L-3; I-3 (Consensus not reached)**
- Feasibility – **H-5; M-8; L-2; I-0**
- Usability and Use – **H-4; M-10; L-1; I-0**
- Overall Recommendation – **NA**
- The Standing Committee failed to reach consensus on this measure; specifically, the Committee failed to reach consensus on Reliability and Validity. It will be designated as “no consensus reached” and put out for public and member comment to gather input from the field before proceeding. The Committee will discuss the measure again on their Post-Comment call held on December 6, 2016. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3090: Appropriate Documentation of a Malnutrition Diagnosis (eMeasure) (Academy of Nutrition & Dietetics)**
 - Developer Representatives: Sharon McCauley, Joe Lynch, Angel Valladeres
 - Votes
 - Evidence – **H-0; M-5; L-4; I-7**
 - Overall Recommendation – **NA**
 - Overall, the Committee did not recommend this measure for endorsement; specifically, the measure did not pass Evidence. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3087: Completion of a Malnutrition Screening within 24 hours of Admission (eMeasure) (Academy of Nutrition & Dietetics)**
 - Developer Representatives: Sharon McCauley, Joe Lynch, Angel Valladeres, Alison Steiber
 - Votes
 - Evidence – **H-0; M-8; L-2; I-6 (Consensus not reached)**
 - Opportunity for Improvement – **H-4; M-9; L-2; I-1**
 - Reliability – **H-0; M-11; L-2; I-3**
 - Validity – **H-1; M-9; L-5; I-1**
 - Feasibility – **H-2; M-12; L-2; I-0**
 - Usability and Use – **H-0; M-11; L-5; I-0**
 - Overall Recommendation – **NA**
 - The Standing Committee failed to reach consensus on this measure; specifically, the Committee did not reach consensus on Evidence. It will be designated as “no consensus reached” and put out for public and member comment to gather input from the field before proceeding. The Committee will discuss the measure again on their Post-Comment call held on December 6, 2016. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3088: Completion of Nutrition Assessment (eMeasure) (Academy of Nutrition & Dietetics)**
 - Developer Representatives: Sharon McCauley, Joe Lynch, Angel Valladeres, Alison Steiber
 - Votes
 - Evidence – **H-0; M-8; L-5; I-3 (Consensus not reached)**
 - Opportunity for Improvement – **H-3; M-11; L-1; I-0**

- Reliability – **M-14; L-3; I-0**
- Validity – **M-12; L-3; I-2**
- Feasibility – **H-1; M-15; L-1; I-0**
- Usability and Use – **H-0; M-14; L-3; I-0**
- Overall Recommendation – **NA**
- The Standing Committee failed to reach consensus on this measure; specifically, the Committee failed to reach consensus on Evidence. It will be designated as “no consensus reached” and put out for public and member comment to gather input from the field before proceeding. The Committee will discuss the measure again on their Post-Comment call held on December 6, 2016. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3089: Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment (eMeasure) (Academy of Nutrition & Dietetics)**
 - Developer Representatives: Sharon McCauley, Joe Lynch, Angel Valladeres, Alison Steiber
 - Votes
 - Evidence – **H-1; M-14; L-0; I-1**
 - Opportunity for Improvement – **H-1; M-11; L-1; I-2**
 - Reliability – **M-10; L-5; I-0**
 - Validity – **M-9; L-7; I-0 (Consensus not reached)**
 - Feasibility – **H-5; M-9; L-2; I-0**
 - Usability and Use – **H-2; M-11; L-2; I-1**
 - Overall Recommendation – **NA**
 - The Standing Committee failed to reach consensus on this measure; specifically, the Committee did not reach consensus on Validity. It will be designated as “no consensus reached” and put out for public and member comment to gather input from the field before proceeding. The Committee will discuss the measure again on their Post-Comment call held on December 6, 2016. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3039~0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (Centers for Medicare and Medicaid Services)**
 - Developer Representatives: Anita Somplasky, KeriAnn Wells, Dan Greene
 - Votes
 - Evidence – **H-2; M-10; L-3; I-1**
 - Opportunity for Improvement – **H-8; M-8; L-0; I-0**
 - Reliability – **H-10; M-6; L-0; I-0**
 - Validity – **M-12; L-4; I-0**
 - Feasibility – **H-4; M-11; L-1; I-0**
 - Usability and Use – **H-7; M-8; L-1; I-0**
 - Overall Recommendation – **Y-15; N-1**
 - Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.

- **2828: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (eMeasure) (Centers for Medicare and Medicaid Services)**
 - Developer Representatives: Anita Somplasky, KeriAnn Wells, Dan Greene
 - Votes
 - Evidence – **H-2; M-10; L-3; I-1** (carried over vote from previous maintenance review on companion measure)
 - Opportunity for Improvement – **H-7; M-7; L-1; I-0**
 - Reliability – **H-1; M-13; L-1; I-0**
 - Validity – First Vote: **M-7; L-8; I-0** Second Vote: **M-10; L-5; I-0**
 - Feasibility – **H-6; M-6; L-3; I-0**
 - Usability and Use – **H-4; M-9; L-2; I-0**
 - Overall Recommendation – **Y-14; N-1**
 - Overall, the Committee recommended this measure for continued endorsement. A summary of the Committee deliberations will be compiled and provided in the draft report.
- **3062: Hypertension Screening for Children Who Are Overweight or Obese (Q-METRIC/University of Michigan)**
 - Developer Representatives: Names of Developers
 - Votes
 - Evidence – **H-0; M-0; L-1; I-13**
 - Insufficient Evidence with Exception – **Y-1; N-13**
 - Overall Recommendation – **NA**
 - Note: The developer attempted to reach NQF staff prior to the in-person meeting to withdraw the measure for endorsement consideration. The measure has since been withdrawn.
- **Next Steps/Committee Timeline**
 - Staff reviewed the project timeline and next steps for the Committee. This includes an opportunity for NQF Member and Public Comment on the draft report from October 20-November 18, 2016; a post-commenting conference call on December 6, 2016; which will be followed by an NQF Member Voting Period; a review and final endorsement decision by the Consensus Standards Approval Committee (CSAC); 30-day Appeals period; and submission of the final report to HHS.

NATIONAL QUALITY FORUM

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HEALTH AND WELL-BEING
STANDING COMMITTEE 2015-2017

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MONDAY
SEPTEMBER 12, 2016

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The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Thomas McInerny, Chair, presiding.

PRESENT:

THOMAS McINERNY, MD, Chair; Professor of
Pediatrics, American Academy of Pediatrics
MICHAEL BAER, MD, Network Medical Director,
AmeriHealth Caritas Family of Companies*
RON BIALEK, MPP, CQIA, President, Public Health
Foundation
JUAN EMILIO CARRILLO, MD, MPH, Vice President,
Community Health, New York-Presbyterian;
Associate Professor, Weill Cornell Medical
College
BARRY-LEWIS HARRIS, II, MD, Chief Executive
Officer, Common Table Health Alliance
CATHERINE HILL, DNP, APRN, Chief Nursing
Officer/Director of Quality, Texas Health
Resources
PATRICIA MCKANE, DVM, MPH, Epidemiologist/SSDI
Coordinator, Michigan Department of
Community Health
AMY MINNICH, RN, MHSA, Director, Geisinger
Health System

JACQUELINE MOLINE, MD, MSc, Vice President and
Chair, Department of Occupational
Medicine, Epidemiology and Prevention,
Northwell Health (formerly North Shore-LIJ
Health System)

MARCEL SALIVE, MD, MPH, Medical Officer,
National Institute on Aging

KATIE SELLERS, DrPH, CPH, Chief Science and
Strategy Officer, Association of State and
Territorial Health Officials

JASON SPANGLER, MD, MPH, FACPM, Executive
Director, Medical Policy, Amgen, Inc.

MATT STIEFEL, MPA, MS, Senior Director, Center
for Population Health, Care Management
Institute, Kaiser Permanente

STEVEN TEUTSCH, MD, MPH, Adjunct Professor,
Fielding School of Public Health,
University of California, Los Angeles;
Senior Fellow, Public Health Institute;
Senior Fellow, Schaeffer Center,
University of Southern California

ARJUN VENKATESH, MD, MBA, Robert Wood Johnson
Foundation Clinical Scholar, Yale
University School of Medicine

NQF STAFF:

ANN HAMMERSMITH, JD, General Counsel

ELISA MUNTHALI, MPH, Vice President, Quality
Management

SHEILA CRAWFORD, Administrative Manager

DIANE FERGUSON, Administrative Assistant

JASON GOLDWATER, MA, MPA, Senior Director

KAREN JOHNSON, MS, Senior Director

ROBYN NISHIMI, PhD, Consultant

YETUNDE OGUNGBEMI, Project Analyst

ALSO PRESENT:

YVETTE APURA, OD, RHIA, PCPI Foundation
DAN BARCH, MS, RTI International*
MARY BARTON, MD, MPP, National Committee for
Quality Assurance
ELIZABETH BOSTROM, MPH, PCPI Foundation
COLENE BYRNE, PhD, RTI International
SEPHEEN C. BYRON, MHS, National Committee for
Quality Assurance
ELVIA CHAVARRIA, MPH, PCPI Foundation
BOB DICKERSON, MSHSA, RRT, Telligen
DIEDRA GRAY, MPH, PCPI Foundation
AMY HELBURN, PhD, RTI International
MEGAN LINDLEY, MPH, Centers for Disease Control
and Prevention*
LISA MCGONIGAL, MD, MPH, Kidney Care Quality
Alliance*
STEPHEN D. PERSELL, MD, MPH, PCPI Foundation*
LINDSEY MARSHALL ROTH, MPP, National Committee
for Quality Assurance
LAURA S. SMITH, PhD, RTI International
JOHN W. WARD, MD, Centers for Disease Control
and Prevention
JENNA WILLIAMS-BADER, National Committee for
Quality Assurance

* present by teleconference

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

2 (8:36 a.m.)

3 MS. MUNTHALI: Okay, we're going to
4 get started. Operator, Shan, if you can open up
5 the lines and make sure the public knows that
6 we're getting started.

7 OPERATOR: Your line is live and you
8 are ready to go. Thank you.

9 MEMBER CARRILLO: Good morning.

10 MS. MUNTHALI: Good morning. Is that
11 Michael?

12 MEMBER CARRILLO: This is Emilio
13 Carrillo.

14 MS. MUNTHALI: Hi, Emilio, how are
15 you?

16 MEMBER CARRILLO: Hi, good morning.

17 MS. MUNTHALI: This is Elisa, we're
18 getting started. I just wanted to welcome
19 everyone to the National Consensus Standards for
20 Health and Well-Being Standing Committee Meeting.

21 This is an in-person meeting for the
22 Health and Well-Being Committee to evaluate and

1 hopefully recommend the measures for NQF
2 endorsement.

3 My name is Elisa Munthali, I'm Vice
4 President for Qualify Measurement at the National
5 Quality Forum. And I wanted to just go over a
6 couple of housekeeping items before I hand it
7 over to my colleagues for introductions and to
8 Tom McInerny, who is your co-chair for our
9 opening remarks.

10 And it's very nice to see everyone.
11 And I wanted to also welcome Steve Teutsch, Matt
12 Stiefel, Barry-Lewis Harris and Anne De Biasi,
13 who's not her today. They're our newest
14 committee members.

15 So next slide please? Great. For
16 those of you who are in the room, our restrooms
17 are just beyond the elevators to the right.
18 We'll have several breaks during the day. Most
19 of them 15 minutes. We hope, if we make
20 progress, lunch will be longer than 15 minutes
21 and it won't be a working lunch, but we'll see.

22 In terms of the Wi-Fi, we've listed

1 the username and password there. So the username
2 is guest, that's lowercase. Password is NQF
3 capital, lowercase guest.

4 And we ask that you please be in the
5 room as much as possible, your votes are really
6 important. That you mute your phones before we
7 get started. And that if you have to take an
8 important call you just step out of this meeting
9 room.

10 And just wanted to let you know that
11 we have microphones for everyone. Only three
12 microphones can be on at the same time. If more
13 than that happens you won't be able to speak.

14 We ask you to move your microphone
15 close to you, as I've done here. Because this
16 meeting is being recorded and transcribed by a
17 court reporter in the back there. And we have
18 folks that are web streaming and also joining us
19 by phone.

20 So I will now turn it over to my
21 colleague, Yetunde, to introduce herself.

22 MS. OGUNGBEMI: Good morning. My name

1 is Yetunde Ogungbemi and I've been with the
2 National Quality Forum for over five years. A
3 little over five years now. I'm excited to work
4 with you all, so welcome. Thank you.

5 MS. MUNTHALI: And I was going to turn
6 it over to Robyn, she's not sitting there, but
7 Robyn Nishimi is our consultant on the project.

8 For those of you who are familiar with
9 NQF, she was our first COO. She's worked with us
10 for many years working on disparities and
11 healthcare -- health competency issues. And of
12 course, population health.

13 And so I'll turn it over to Sheila
14 Crawford for an introduction as well.

15 MS. CRAWFORD: Good morning. I'm
16 Sheila Crawford, administrative manager for the
17 department. And I'm here to help out without
18 whatever you need me to be. Thank you and
19 welcome.

20 MS. MUNTHALI: And also helping Sheila
21 is Diane Ferguson who is walking around giving
22 clickers to everyone.

1 And another colleague of ours, who
2 you'll meet throughout the next two days, Karen
3 Johnson, who is our chief methodologist. She's a
4 senior director here. And she'll be to the left
5 of Yetunde.

6 So I'll turn it over to Tom for any
7 opening remarks before we turn it over to Ann
8 Hammersmith, our general counsel for disclosure
9 of interests and introductions of the entire
10 committee.

11 CHAIR McINERNY: Good morning everyone
12 and thank you for taking the time out of your
13 busy schedules to come down to D.C. for this
14 meeting. And we appreciate your time that you
15 also have done in analyzing the measures. And
16 we'll look forward to your comments.

17 And I also want to thank, very much,
18 the NQF staff, for their very helpful sort of
19 pre-analysis and giving us some ideas about each
20 of the measures. I think it made my studying of
21 the measures significantly easier and I
22 appreciate that very much.

1 MS. MUNTHALI: Thank you. Ann.

2 MS. HAMMERSMITH: Good morning
3 everyone, I'm Ann Hammersmith. I'm NQF's General
4 Counsel. I'll lead you through the oral
5 disclosures of interest.

6 If you recall, we sent you a rather
7 long form where we asked you about your
8 professional activities. And what we do at the
9 beginning of each meeting, the very first
10 meeting, is we ask the committee members to go
11 around the table and tell us if you have anything
12 to disclose.

13 We are only interested in your
14 disclosure of activities that are directly
15 related to the subject matter before you. So if
16 you did something in another area, you need not
17 disclose that.

18 We are particularly interested in your
19 grants, research activity, speaking, but only if
20 it's related to the matter at hand.

21 Just a reminder that you sit on this
22 committee as an individual, you don't represent

1 your employer or anyone who may have nominated
2 you to sit on this committee.

3 The other reminder is, some people
4 will, when we go around the table, will say no
5 financial conflict of interest, which is great,
6 but we are also interested in things that may not
7 involve any exchange of funds.

8 So for example, if you served on a
9 committee that's relevant to the measures before
10 the committee, that may have been without
11 compensation, but we would still be interested in
12 hearing that.

13 So let's go around the table. If
14 you're on the phone, I will call your name. Tell
15 us who you are, who you're with and if you have
16 anything to disclose. Let's start with the
17 Chair.

18 CHAIR MCINERNY: Hi, Tom McInerny. I
19 am the past president of the American Academy of
20 Pediatrics and Professor Emeritus of the
21 Department of Pediatrics at the University of
22 Rochester Medical Center. I have no disclosures.

1 MEMBER SALIVE: Good morning. I'm
2 Marcel Salive. I'm a medical officer at the
3 National Institute on Aging of NIH and I have no
4 disclosures.

5 MEMBER TEUTSCH: I'm Steve Teutsch.
6 I'm mostly retired, but I work at UCLA on
7 economic modeling and at the Public Health
8 Institute in Oakland. And at the USC Institute
9 for Policy and Economics.

10 I actually work on lots of different
11 metrics group. Do you want me to list what those
12 are?

13 MS. HAMMERSMITH: I don't think that's
14 necessary, unless you think it's a conflict.

15 MEMBER TEUTSCH: I don't think it's a
16 conflict.

17 MS. HAMMERSMITH: Okay.

18 MEMBER TEUTSCH: But --

19 (Simultaneous speaking.)

20 MEMBER BIALEK: Good morning. I'm Ron
21 Bialek, president of the Public Health
22 Foundation. I have nothing to disclose.

1 MEMBER MOLINE: Good morning. I'm
2 Jacki Moline, I'm the Chair of Occupational
3 Medicine Epidemiology and Prevention, formally
4 Population Health, at Northwell Health in New
5 York. And I have nothing to disclose.

6 MEMBER MCKANE: Hi, I'm Patty McKane
7 and I'm now the Division Director for the
8 Lifecourse Epidemiology & Genomics Division, or
9 actually acting division director, at Michigan
10 Department of Health and Human Services. And I
11 have nothing to disclose.

12 MEMBER SELLERS: Good morning, I'm
13 Katie Sellers. I am the Vice President for
14 Maternal and Child Health Evaluation and
15 Improvement at the March of Dimes. And I have
16 nothing to disclose.

17 MEMBER VENKATESH: Hi everyone, my
18 name is Arjun Venkatesh. I'm an emergency
19 physician at Yale University.

20 I work under contract with the Centers
21 for Medicare and Medicaid Services in development
22 of hospital outcome and efficiency measures. So

1 none of the measures that are considered here.

2 And I also do have some research
3 funding from the Emergency Medicine Foundation
4 that uses several of the AHRQ PQI admission rates
5 as an outcome.

6 MEMBER SPANGLER: Good morning, I'm
7 Jason Spangler. I'm an executive director of
8 U.S. Health Policy and Reimbursement at Amgen.
9 And nothing to disclose.

10 MEMBER MINNICH: Good morning. My
11 name is Amy Minnich, I'm the Senior Clinical
12 Informaticist at Geisinger Health System. And I
13 have nothing to disclose.

14 MEMBER HARRIS: Good morning. My name
15 is Barry-Lewis Harris, the CEO of Common Table
16 Health Alliance. And I have nothing to disclose.

17 MEMBER STIEFEL: Hi, Matt Stiefel from
18 Kaiser Permanente. I'm the director of the
19 Center for Population Health. And I have nothing
20 to disclose.

21 MEMBER HILL: Hi, I'm Catherine Hill
22 and I am nurse practitioner, a member of the

1 American Nurses Association, and an inpatient
2 nurse practitioner who still practices daily.
3 And I have nothing to disclose.

4 MS. HAMMERSMITH: Okay, thank you.
5 Now I'll call on the people on the phone. Juan
6 Emilio Carrillo.

7 MEMBER CARRILLO: Yes, hi. This is
8 Emilio Carrillo. I am the Vice President for
9 Community Health at New York-Presbyterian. I
10 have nothing to disclose.

11 Will join you in person later in the
12 afternoon. I will be in travel today. Thank
13 you.

14 MS. HAMMERSMITH: Okay, thank you.
15 Michael Baer. Is Michael Baer on the phone?

16 OPERATOR: He has not dialed in yet.

17 MS. HAMMERSMITH: Okay, thank you,
18 Operator. Before I leave you, I just want to
19 remind you of one more thing.

20 If during the meeting you believe that
21 you have a conflict of interest, if you think a
22 fellow committee member has a conflict of

1 interest or if you think someone is behaving in a
2 very biased manner, please speak up in real-time.
3 We don't want you to get three months out and
4 then say, you know, I think I had a conflict of
5 interest.

6 So if you like, you can speak up in
7 the meeting. If you prefer not to do that, you
8 can go to your co-chair, who will talk to NQF
9 staff, or you can go directly to NQF staff.

10 Any questions of me or of your fellow
11 committee members? Okay, thank you.

12 MS. MUNTHALI: Thanks Ann. Next
13 slide. Great. One of the things we forgot to
14 mention is that your other co-chair, Amir, will
15 not be here today but he'll be here tomorrow.
16 There was a scheduling conflict.

17 So what I wanted to do, before we get
18 started, is to briefly go over our Health and
19 Well-Being portfolio. You heard much of this
20 information when we went through the orientation
21 and Q&A call, but we think it's important just to
22 remind you.

1 Our work around health and well-being
2 and population health, with regards to the
3 endorsement of measures, started in 2011. With
4 foundational work that one of your colleagues on
5 the committee lead, Steve Teutsch. Steve Teutsch
6 and John Jacobson.

7 We commissioned them to write a paper
8 and help us to think about how we should be
9 measuring and assessing population health. What
10 we were trying to do is come up with a
11 measurement framework. And as you can image,
12 when you bring so many different stakeholders
13 together, very difficult to land on one of those
14 frameworks.

15 Ron was a part of that work and so was
16 Jason. And so was Matt. But what we did come up
17 with was really some guiding principles on how we
18 should be looking at population health.

19 Steve and Don encouraged us not to
20 just look at total population, but also to look
21 at the determinants of health that are outside
22 the clinical delivery system. And also look at

1 healthy lifestyle behaviors. And also health
2 improvement.

3 And so our portfolio is really formed
4 around these tenants that Steve and Don worked on
5 and encouraged NQF to follow through. And also
6 on the National Quality Strategies.

7 So our measures are primarily around
8 health lifestyle behaviors, primary prevention
9 and screening. And we do have a few on those
10 social and economic determinates of health that
11 can be modified. And a number of oral health
12 measures as well.

13 Right now, today, you'll be reviewing
14 24 measures. Ten of these have come through our
15 process before. These are what we call
16 maintenance measures. Fourteen are new.

17 This is pretty unique for NQF.
18 Normally, in a given topical area, most of the
19 measures that we look at are maintenance
20 measures. So this is a good sign that measure
21 development in this area is growing.

22 The measures are primarily around

1 primary prevention and screening. A lot of the
2 influenza vaccine measures that you reviewed.

3 And there is cervical screening,
4 cancer -- cervical cancer screening measures as
5 well. And then there is some healthy lifestyle
6 behavior measures around BMI screening.

7 Next slide. So this is just a
8 snapshot of the maintenance measures I mentioned
9 earlier. As you can see, most of them are around
10 the influenza vaccines. And we'll talk about
11 this in great detail. There are a number of
12 them. There are eight measures. And then
13 there's one that's an outcome measure.

14 So those are all process measures.
15 The influenza vaccine measures.

16 There is one process -- outcome
17 measure, I'm sorry. It's a bacteria and
18 pneumonia measure. That's also a maintenance
19 measure under review.

20 Next slide. And these are some of the
21 newer measures we have under review. You'll see
22 that many of them are electronic clinical quality

1 measures, or eMeasures.

2 That is quite good for this project as
3 well. You don't see that many across our topical
4 areas, but quite a few came in to this project.
5 So we just wanted to give you a snapshot of the
6 new measures that are under review. The 14.

7 Next slide. So what we did here is
8 breakdown our portfolio so you can really see
9 where we have gaps.

10 We do have quite a few measures in the
11 primary prevention and screening. A number of,
12 not just influenza vaccine measures, but
13 pneumococcal vaccine measures as well.

14 But in those measures in which we can
15 see the determinants of health, we don't have
16 that many. And also in the areas of healthy
17 lifestyle behavior or those that are a community-
18 level indicators of health and disease.

19 Our portfolio is growing around oral
20 health. Last time I think you reviewed about
21 three or four oral health measures. And those
22 were some of the newer measures that came into

1 our portfolio. So definitely a lot of work in
2 most of these subtopic areas or measure domains.

3 Do you have any questions? Okay,
4 great. I'll turn it over to Robyn.

5 DR. NISHIMI: Thanks. Thanks, Elisa.
6 I think I was out for introductions, so I did
7 want to mention one thing.

8 I was involved in the testing of the
9 influenza measure. So unlike almost all of you,
10 I do have something to disclose. And so I will
11 be recusing myself from all the influenza
12 vaccination measures.

13 So with that said, can I have the next
14 slide? I'm just going to go over a little bit,
15 to remind you, before you we actually get into
16 the discussion, about the differences in the new
17 maintenance process. Because Tom will be queuing
18 you a few points to ask you whether you feel you
19 need to vote at all, because of the previous
20 committee's deliberations. So I wanted to
21 explain why that would happen.

22 You all have seen the measure

1 worksheets. If you log into the SharePoint
2 sites, from your computer here, you'll be able to
3 access the most current ones so that you can see
4 the additional comments that may have come in
5 over the weekend.

6 There were some more comments this
7 morning, so we'll be populating those. They're
8 largely for measures tomorrow. But if you have a
9 measure tomorrow, you may want to look at that
10 worksheet again.

11 So on the worksheet, you've seen the
12 preliminary analysis for each measure that was
13 performed by staff. And now you'll see the -- in
14 the orange section, the Committee's comments.

15 We did not get any pre-meeting or
16 member comments so those aren't there. And then
17 you've had the evidence and testing, if you
18 looked at those. And they're all attached into
19 that big file.

20 We wanted to emphasize that the
21 staff's preliminary analyses really are just the
22 starting point to help you facilitate your

1 presentations, as well as pull out, what we
2 thought, as staff, were some of the salient
3 facts. They're just meant as a starting point.

4 You may completely disagree with them,
5 and that's just fine. And, you know, welcomed.
6 So just wanted to emphasize that we don't intend
7 those to be binding or determinative.

8 Can I have the next slide? In terms
9 of the way we evaluate the measures, as you know,
10 importance is the first criterion. For new
11 measures, you're asked to look at whether the
12 quantity, quality and consistency of the
13 evidence, whether there were guidelines, whether
14 the evidence was graded, et cetera.

15 Under the maintenance process there's
16 decreased emphasis here. Developers are asked
17 either to attest that there's no new evidence or
18 update the evidence, if it's relevant.

19 In many cases, the update is merely
20 updated guidelines, so that the evidence is
21 directionally all still the same. So there's
22 decreased emphasis here and you may decide not to

1 vote at all.

2 For instance, when we get to the
3 influenza immunization measures, they all
4 basically have the same measures. So we will
5 queue you at that point to ask whether you just
6 want to vote on evidence for all influenza
7 measures so that you don't have to discuss and
8 vote on it for all eight of the measures. It
9 seems to us to be a little bit ridiculous. So
10 when we get to that point, Tom will queue you
11 there.

12 The other part of importance is gap.
13 Gap is the opportunity for improvement. With a
14 new measure, we like to see some data, if it's
15 available, either through testing or perhaps the
16 literature in the general area.

17 But there's increased emphasis on gap,
18 obviously, for a previously endorsed measure.
19 Because hopefully its measures been in use so
20 hopefully there's more gap information.

21 You may see that the gap isn't closing
22 or there hasn't been any improvement over the

1 past five years. So then you, as a committee,
2 would have to discuss whether in fact this
3 measure is doing what you would like it to do in
4 quality improvement.

5 It might be that the mean performance
6 is about the same. But if you look at the range
7 it's been narrowing or there's still a
8 substantial proportion.

9 You know, the 20th percentile or the
10 10th percentile for instance are still lagging
11 far behind, so that's a judgment you'll have to
12 make. Whether the gap is still there. But
13 there's increased emphasis on the gap.

14 Next slide. So for scientific
15 acceptability, there's no difference. You look
16 at the specifications and decide if they're still
17 relevant. Sometimes the specifications have been
18 updated, sometimes they haven't been.

19 For reliability and validity testing,
20 for new measures, very important that they be
21 tested, very important that they be tested in the
22 data systems that they're intended to use for.

1 That's an NQF requirement.

2 There is decreased emphasis on testing
3 of a maintenance measure. Developers have been
4 through the cycle, they've tested it. They may
5 update their scores. They may provide new score
6 level testing where previously they only had data
7 element testing.

8 But overall, there's a decreased
9 emphasis because the assumption is that the
10 previous committees, again, have looked at this.
11 Have decided that it was reliable and valid.

12 And so you will be asked whether or
13 not you want to vote on it again. You can always
14 say yes and shouldn't feel shy about saying yes,
15 if you disagreed with the previous committee's
16 assessment.

17 But overall, there should be decreased
18 emphasis on discussing and picking apart the
19 testing for a maintenance measure.

20 And then the last two criteria that I
21 just wanted to mention, feasibility. You'll
22 discuss feasibility and vote on feasibility.

1 There's no difference.

2 And in fact, with a maintenance
3 measure, they may have uncovered implementation
4 issues. So should vote there.

5 And then usability and use, there
6 should be increased emphasis. There should be a
7 demonstration now that this is an endorsed
8 measure of use in either accountability or
9 quality improvement. And there should be an
10 identification of whether there is unattended
11 consequences, once it's been implemented.

12 So again, feasibility, there's no
13 difference, you should discuss whether it's
14 feasible or not. And then usability and use, for
15 a maintenance measure, increase the emphasis.

16 Any questions on how the difference?
17 And we're going to approach our maintenance first
18 versus new measures. Our first batch is the
19 maintenance, so. Okay.

20 CHAIR MCINERNY: Thank you.

21 MS. OGUNGBEMI: Good morning. I am
22 going to announce the role of the standing

1 committee, which is all of you.

2 So as a standing Committee Member you
3 are to act as a proxy for NQF's multistakeholder
4 membership. You serve in two or three year
5 terms, which is picked at the beginning of every
6 project cycle.

7 You work with NQF staff to achieve the
8 goals of the project and you review all of the
9 measures in the portfolio, as they are submitted.

10 You indicate the extent to which each
11 criterion is met and the rationale for its
12 rating, which will be delivered in a report.

13 You make recommendations to NQF for
14 endorsement of measures. You respond to comments
15 during the review period that are submitted. And
16 you respond to any directions from the CSAC. You
17 also oversee the portfolio of health and well-
18 being measures.

19 Next slide please. So I'm also going
20 to talk to you about the ground rules for today's
21 meeting. During the discussions, committee
22 members should be prepared with having reviewed

1 your measures beforehand, which I know that you
2 all did. Thank you very much for doing it on
3 such short notice.

4 You're basing your evaluation and your
5 recommendations on the measure evaluation
6 criteria and the guidance. And you will use
7 algorithms, which are at each of your places,
8 place seatings, to move through the measures and
9 vote on the criteria individually.

10 Please remain engaged in the
11 discussion and mute your phones or put them on
12 vibrate, if you are able please.

13 You can attend -- of course you're
14 supposed to attend the meeting and excuse
15 yourself for breaks if you need them. Keep your
16 comments concise and focused.

17 And we ask that you please do not
18 repeat your other committee member's sentiments
19 in full. If you'd like to express your
20 agreement, please do so though.

21 Avoid dominating the discussion with
22 your point. Please make it known what you feel

1 and we can move on peacefully.

2 And next slide please. I'm also going
3 to go over the process for measure discussions.

4 In the back of the room, and on the
5 phone, we have measure developers who are
6 attending our in-person meeting. They will use
7 that time, the two to three minutes that we allot
8 to them, to introduce their measure for two to
9 three minutes.

10 The lead discussants, which is
11 included on your agenda, they will also introduce
12 the measure to the committee. You'll basically
13 tell the committee, your fellow committee
14 members, anything that you feel is necessary to
15 bring up. Anything that pops out at you or that
16 you would definitely like to discuss with the
17 committee members.

18 Developers will be available to
19 respond to questions, but only at the discretion
20 of the committee. So you can call on the
21 developer to answer your questions. The
22 developer will not just insert themselves into

1 your discussion.

2 Committee members will also vote on
3 criteria and sub-criteria.

4 MS. MUNTHALI: So we also wanted to go
5 over, very briefly, what we --

6 MEMBER CARRILLO: May I interrupt for
7 a minute?

8 MS. MUNTHALI: Sure.

9 MEMBER CARRILLO: This is Emilio
10 Carrillo.

11 MS. MUNTHALI: Hi, Emilio.

12 MEMBER CARRILLO: I will be in transit
13 at 9:50 when 0032: Cervical Cancer Screening
14 comes up and I'm prepared to introduced to that
15 measure. I wonder if someone else from the
16 group, my group, can present it at that time or
17 else change the presentation until tomorrow
18 morning?

19 MS. MUNTHALI: Unfortunately we have
20 the developers here and they're scheduled to be
21 here. I think Barry-Lewis Harris is your co-
22 discussant. So perhaps, Barry, would you be

1 comfortable introducing the measure?

2 MEMBER HARRIS: Sure.

3 MS. MUNTHALI: Barry said sure.

4 MEMBER CARRILLO: Thank you very much.

5 My apologies.

6 MS. MUNTHALI: No problem. So what
7 I'm going to do now is go over voting for the
8 endorsement criteria. This is really just
9 reemphasizing what Robyn went through.

10 So in terms of importance to measure
11 and report, Robyn told you what is comprised of
12 that. The committee would be voting on evidence.

13 And if there are no changes to the
14 evidence, you can opt, as a group, not to vote on
15 that. So no change.

16 This would be only for maintenance
17 measures. Maintenance measures, again, are
18 measures that have come through our process in
19 the past and they're up three year re-look on all
20 of the criteria.

21 So if you decide not to vote on that,
22 we can skip that. But we definitely want to know

1 how the measure is performing.

2 So performance gap is a must vote.
3 You must vote on that. Whether it's a new
4 measure or not.

5 With regards to testing, the
6 scientific acceptability of the measurement
7 properties, if there are no changes to
8 reliability and validity, the committee can
9 decide not to vote. But if there have been
10 changes, we definitely want you to vote on those
11 criteria.

12 There are two separate criteria
13 underneath scientific acceptability of the
14 measure properties. Again, if it's a new
15 measure, it's not optional, you have to vote.

16 In terms of feasibility, with our new
17 emphasis on maintenance to know how measures are
18 doing out in the field, we definitely want to
19 vote on feasibility and usability and use. It's
20 also required.

21 So next slide. So in terms of
22 achieving consensus. A pass or recommended has

1 to be greater than 60 percent yes votes of the
2 quorum. So that's not the quorum of the entire
3 committee, it's the quorum of those that are
4 participating in the meeting.

5 And so for example, 61 percent on yes
6 would be a recommend for endorsement.

7 Consensus is not reached if it falls
8 within 40 percent or 60 percent, inclusive of the
9 40 and 60. And of course, that would be a quorum
10 of the committee.

11 And the measure is not recommended or
12 does not pass if it's less than 40 percent. So
13 39 percent of votes of yes. And a quorum of 60
14 percent of the committee.

15 And I think there are 20 of us here
16 and so we have the numbers. I don't have them
17 off the top of my head, but we have that. So
18 we're going to watch that, make sure we have
19 quorum throughout the next two days.

20 Okay, great. So as I mentioned
21 before, unlike of a lot of other projects, we
22 have a number of eMeasures in this project. I

1 think ten.

2 We do have staff experts with us at
3 NQF that know all of the details and
4 requirements. And one of those is Jason
5 Goldwater, who is our senior director, who
6 specializes in all of our HIT and eMeasures work.
7 And so we thought it would be helpful for him to
8 give a review, an overview, of the measure
9 evaluation criteria for these types of measures.
10 Jason.

11 MR. GOLDWATER: And thank you, Elisa,
12 for that wonderful introduction that I clearly
13 don't deserve.

14 So I'm sure this is the part of the
15 morning that you all were looking forward to the
16 most, as we talk about how to review eMeasures
17 right. You don't have to lie, it's fine. If you
18 don't have caffeine, I would strongly recommend
19 getting some soon.

20 Elisa is right. There were an awful
21 a lot of eMeasures that were submitted as part of
22 this project. Far more than we have seen in

1 others. Which is great.

2 This is certainly where we are
3 transitioning to. We're moving ourselves away
4 from exclusively relying on chart extracted
5 measures and into eMeasurement.

6 Some of you may remember when CMS,
7 back in the good old days when it was called
8 HCFA, when they were first promoting the idea of
9 doing this all those years ago. And it did not
10 succeed then because EHR adoption was extremely
11 low. Both in hospitals and provider settings.

12 And now, as we are approaching the end
13 of 2016, we're roughly at 80 percent adoption in
14 both provider settings and also in hospitals. So
15 the time for electronic clinical quality measures
16 is certainly here.

17 And I think it was very encouraging
18 for all of us to see so many health and well-
19 being measures being submitted that were
20 leveraging the data that is found within EHRs, or
21 registers, to be able to look at the performance
22 of a measure without necessarily relying on

1 manual abstraction.

2 So this particular project included
3 the evaluation of ten eMeasures. Some of which
4 were being considered for what we call trial use.

5 So, as I'll get to a little bit later,
6 there's a number of different ways you look at
7 eMeasures. There's really four different
8 pathways that an eMeasure can take as it comes
9 into NQF.

10 It can be a brand new measures, a de
11 novo measure, it can be a legacy measure, which
12 is a measure that is already in existence in a
13 public program, federal program, that has been
14 respecified as an eMeasure. It could be a
15 respecified measure, which is a claims measure or
16 a chart abstracted measure that's now being
17 respecified electronically, or it can be this,
18 which is trial use.

19 Why did we come up with trial use?
20 The NQF endorsement criteria for eMeasures
21 requires that when you're testing a measure, it
22 has to be tested in at least more than one EHR

1 system. Or as I often joke, at least two. It's
2 all in the wording, in how we word it. So at
3 least two different EHR systems.

4 Now that often leads to the question,
5 well, I've tested it in two hospitals, they both
6 have Epic. Which at this point, who doesn't have
7 Epic. So doesn't that, is that considered two
8 different EHR systems? And yes, it is.

9 Because there's no one Epic
10 implementation that is like another Epic
11 implementation. They are all very customized for
12 the settings that they are a part of.

13 But testing a measure in at least two
14 EHR systems, at times, is difficult.
15 Particularly if it's a brand new measure that has
16 never been utilized before.

17 So the question before NQF was, do we
18 stop that innovation and allow that measure to
19 fall because they are unable to test it, or can
20 we find a pathway that would allow that measure
21 to be implemented because it's clearly filling a
22 gap, it clearly represents innovation and it's

1 clearly needed, but it hasn't fully met our
2 testing requirements. And so that was the Trial
3 Use Program.

4 Now the Trial Use Program is a path to
5 endorsement for new innovatively electronically
6 specified measures that can't satisfy our testing
7 criteria yet, but they are ready to be
8 implemented in the real world settings.

9 The specifications are there, they're
10 able to take the data from an EHR. It is, for
11 the most part, structured data. So it does not
12 pose a burden to collect, but they just simply
13 have not been able to test within two settings.

14 It's very important to note, very
15 important to note, that when you are looking at
16 eMeasure for trial use, you are not looking to
17 endorse the measure. Now, that's going to be
18 unlike a lot of the things you're going to do
19 over the next day and a half.

20 Which are, you're going to be
21 reviewing measures and determining whether they
22 should get an NQF endorsement.

1 When you're looking at a trial use
2 measure, and you're voting, it's not for
3 endorsement. It's to be accepted into the Trial
4 Use Program.

5 So what does that mean? It means that
6 the measure, if it's approved by all of you,
7 which means you think it is reliable, you think
8 it's valid, you think it's feasible, you think
9 it's usable and you believe that there is enough
10 scientific acceptability to warrant the measure,
11 then the measure is put into the Trial Use
12 Program, which means the developer can go
13 implement it, find places to implement that
14 measure. Whether it's in a hospital or a
15 provider setting.

16 And they are given a three-year window
17 to implement that measure, collect data. Once
18 they have enough data that satisfies their
19 ability to test reliability, validity,
20 feasibility and usability, then they can come
21 back, to all of you, and say, we've had this
22 measure in the Trial Use Program and here is our

1 testing data. And then you look at it and
2 determine whether it should be endorsed or not.

3 So essentially what you're approving
4 is the measure to be tested in a real world
5 setting. Not a simulated setting, or not in a
6 controlled environment in which they would be
7 looking at two EHRs over a defined timeframe, but
8 rather you are approving that the measure can go
9 forward, be implemented.

10 They can collect data over the next
11 three years, if it takes that long. Once they
12 have enough data, they can evaluate the results,
13 come back to you and determine whether the
14 measure should then be passed and approved for
15 endorsement.

16 And it is a possibility that when a
17 measure is implemented, the data they get back,
18 may indicate that it's not overly reliable. Or
19 perhaps it is not feasible. That's what the
20 implementation is there to do. Is to test for
21 that.

22 Next slide. So you will consider the

1 full NQF criteria when reviewing these measures
2 for approval. So everything that you have
3 already gone over you will look at. You will
4 review these measures as you would any other,
5 it's just simply not being reviewed for
6 endorsement.

7 Evidence and performance gap,
8 importance to measure and report, R&D voting
9 criteria, as they would be for any measure. So
10 if it doesn't get pass those two, the measure
11 doesn't go forward.

12 You will vote on one portion of
13 scientific acceptability to determine if the
14 measure specifications are consistent with the
15 evidence. This is a must pass. If it doesn't
16 pass, doesn't get put into the program.

17 Feasibility and usability and use
18 should also be considered for determining if a
19 measure should receive approval for trial use.

20 Now you may be asking, well, if they
21 haven't tested the measure, how exactly are we
22 supposed to be evaluating that? Good question.

1 So what we have allowed the developers
2 to do, when they want to look at a measure for
3 trial use, is to simulate a data set that tests
4 the logic of the measure to determine that the
5 appropriate metric is being calculated as it
6 should be. And the way they use this is through
7 a program through Bonnie.

8 And I always joke when I say this,
9 because I inevitably get asked this question,
10 well, what does Bonnie stand for? Nothing. I
11 don't know what it stands for.

12 A long time guess has always been
13 that, having been a developer in a past life,
14 which rarely admit, we are very fond of naming
15 applications after our children or our pets. So
16 Bonnie could be one of those two.

17 What Bonnie does is it allows you to
18 create a simulated test deck of patients. So
19 patients with criteria and characteristics that
20 would be representative of the real world. And
21 then you can test the measure against that
22 simulated test deck to make sure the measure is

1 calculating correctly.

2 Now, when you look at that, it's very
3 important to note that you want to make sure that
4 the measure is working. Which means, it's taking
5 in the patients it should be and it is excluding
6 the patients that should not be put into the
7 measure.

8 So if somebody presents to you a list
9 of 50 simulated patients and every one of them
10 would fit into the measure, that's not
11 necessarily adequately being comprehensive
12 enough. And that's a question you may want to
13 ask.

14 They really want to use Bonnie to
15 adequately test, in a simulated environment,
16 whether the measure would work correctly or not.

17 Next slide. Fully specified
18 eMeasures. The committee will consider the full
19 NQF criteria when reviewing these measures. So
20 every criteria that Elisa went over is the same
21 criteria you would use for an eMeasure.

22 The specifications are a bit different

1 than it would be for a chart abstractive measure
2 because you're using coded data within a system.
3 But that does not negate, nor diminishes, the
4 importance of the criteria that you use to
5 determine whether a measure should go forward for
6 endorsement.

7 The requirements for eMeasure
8 specifications, and I reviewed, I think all of
9 these myself, so I can tell you that most of
10 these at least passed these initial requirements.
11 So an eMeasure has to be in a very specified
12 format.

13 Without really getting into deep talk,
14 which Elisa and Karen will tell you I do
15 frequently, it has to be laid out in a way that
16 it can be transported from system to system,
17 without the measure or the data being
18 compromised.

19 So if I am passing my information from
20 one system to another, it looks the same. I open
21 it up and it's the same data that it would be
22 when it was originated. And so that's the called

1 the Health Quality Measures Format.

2 It has to be mapped to a data model.
3 In this case we're using the Quality Data Model.
4 And what that means is that the way information
5 is represented, an encounter, a diagnosis, a
6 procedure, is all represented the same way.

7 So when they represent a procedure,
8 they're using the appropriate elements for a
9 procedure. When they're looking at a diagnosis,
10 they're representing the proper elements for a
11 diagnosis.

12 And then the measure is populated with
13 that we call value sets. So a value set is
14 basically a representation of a condition, a
15 diagnosis, a procedure.

16 So major depressive disorder is a
17 value set. And they have coded elements that
18 represent what major depressive disorder is.

19 Back in the days when this was first
20 started, there was no guidance on value sets. So
21 anybody could create a value set. And that of
22 course led to every measure developer creating a

1 value set without actually knowing if another
2 measure developer had created something very
3 similar.

4 So the National Library of Medicine
5 created the Value Set Authority Center, which
6 basically is the library of every available value
7 set.

8 So when developers are building
9 measures electronically, they go to what we call
10 the VSAC, or this Value Set Authority Center
11 library, and they pull the value sets that they
12 need. If they can't find the value set that is
13 appropriately representing what they want in a
14 measure, then they can go ahead and create one.

15 What we ask for in all of these
16 criteria, is that the value sets are published.
17 So when you write a value set and submit it to
18 the National Library of Medicine, you have to
19 publish it. And that way everybody can use it.
20 It's not just exclusive to the developer. It's
21 open and available for everybody.

22 And there have been times when they

1 haven't been published. So what we want is that
2 the value sets are accessible to everyone, in the
3 hopes that eventually we will see value sets
4 being used repeatedly to represent similar
5 conditions.

6 The feasibility assessment, which is
7 done through a scorecard, is required to
8 demonstrate how the data elements included in the
9 measure and logic are used to complete the
10 measure. So when they test for feasibility it
11 is, is the logic calculating correctly, does the
12 metric match the objective of the measure, are
13 the denominator and the numerator being populated
14 as they should be, and most importantly, are
15 those patients that should be excluded from the
16 measure being excluded appropriately as well.

17 Next. So here are the measures that
18 you will be looking at, in terms of those that
19 will be under the trial use, as well as fully
20 specified eMeasures.

21 I'm not going to spend time reading
22 every single one of these, but certainly you can

1 see there are quite a bit. Which we find
2 incredibly encouraging. And we find helpful.

3 Because I think this is, again, is
4 sort of the way where we are transitioning to.
5 And so we appreciate the work on behalf of the
6 developers and the stewards, for moving us in
7 this direction.

8 What I do want to emphasize, as I
9 often do when I do this, is the criteria that you
10 are using to judge, evaluate these measures, is
11 the same as you would with any other measure.
12 It's not changing.

13 Except that the testing has to be done
14 in at least two EHR systems. And that when you
15 are looking at trial use, which will be
16 designated by this group, that when you are
17 considering that, you're not considering that for
18 endorsement, it's just simply to be put into the
19 Trial Use Program. And that measure will come
20 back to you, after they have enough data that
21 they can sufficiently test the measure.

22 Next slide. Okay, any questions?

1 Sir.

2 CHAIR McINERNEY: I'm wondering how the
3 EHR codes things in the area of the history and
4 the physical exam? And in the history
5 particular, past history, review of systems,
6 family history.

7 Because some of these measures are
8 very important that the history of whether or not
9 a patient has had in testing or has had a
10 disease, has been recorded. And I'm not sure
11 that the Electronic Health Record is capable of
12 doing that in all cases.

13 MR. GOLDWATER: That's an excellent
14 question, and you are correct. It is not alike
15 in any one of the EHR system.

16 In most cases, past family history is
17 what we would call unstructured data. It's a
18 free text that's usually entered into provider
19 notes in the section of the EHR.

20 Now, there are a couple of EHR
21 systems, that I'm aware of, where you can
22 actually fill out a text field in a dropbox that

1 would indicate conditions or diagnoses that
2 relate to the family history. Epic has that
3 option, Cerner has that option.

4 That does not necessarily mean that
5 every EHR does. Nor does it necessarily mean
6 that even when they have tried, to their best to
7 structure that information, that it's giving you
8 the full amount of information that you may deem
9 necessary.

10 In some of the measures that we
11 initially looked at, that did not seem to present
12 that much of a difficult problem. But that is
13 certainly something to consider in the
14 evaluation.

15 CHAIR McINERNEY: Yes, because I'm
16 reminded of the saying, we see only what we look
17 for. And I think EHR see only what they look
18 for.

19 And it may be that as we are requiring
20 hospital systems and physicians to do more in the
21 way of eMeasures, the EHRs will need to be
22 structured a little more carefully so that they

1 are looking for certain parameters to help them
2 decide whether the patient belongs in the
3 denominator or the numerator. And that could be
4 a problem if it's not doing that well.

5 MR. GOLDWATER: That's correct. And
6 I -- there's only two things I can say. Is that,
7 one, as you approach an eMeasure, that will be
8 described as to how that data was collected. And
9 if it is unstructured free text, then the
10 evaluation will have to be determined whether or
11 not that measure actually is reliable and valid,
12 and more importantly, feasible.

13 Secondly, half-heartedly, I'm happy to
14 give you the Epic customer service number and you
15 can call and tell them what many of us have been
16 saying for years, that they should find ways of
17 structuring this. Because it does make eMeasure
18 easier.

19 Particularly in areas such as this.
20 In which past history is a very important
21 component of this.

22 Any other questions? I must be

1 getting much more fluent at this, at least I'm
2 assuming. Stunning people in their tracks
3 amazingly.

4 Okay. Well, I will be around so if
5 there is anything that you all need I'm happy to
6 answer. If I'm not actually present, physically
7 in the office, I'm more than happy to dial in.
8 So if you have any questions, please feel free to
9 ask.

10 Thank you all very much for your time
11 and I hope you enjoy the next day and a half. I
12 know Yetunde and Elisa will take excellent care
13 of you, as they often do.

14 MS. MUNTHALI: Thanks, Jason. So we
15 are now ready for review of our first measure.
16 This is measure 0032: Cervical Cancer Screening.

17 The developers are the NCQA. And
18 we'll ask the NCQA developers to come up to the
19 table, to the left of me.

20 And while they are preparing to come
21 here, I think they're in-person, we just wanted
22 to remind you about the voting process in front

1 of you. Everyone should have a blue clicker.
2 Yetunde will go through, after we review the
3 first major criterion, how to use the clickers.

4 But what we're going to do is have a
5 two to three-minute presentation, by each
6 developer. NCQA will do that. Will discuss the
7 first major criterion on evidence. Then we'll
8 vote on that.

9 Then we'll discuss, you know, assuming
10 the measure goes through evidence, then we'll
11 discuss performance gap, vote on that.

12 Then go onto scientific acceptability,
13 vote on reliability. Then have a discussion on
14 validity, and so on. So we'll be queuing you as
15 we go forward. So, Sepheen.

16 MS. ROTH: Hi, good morning. I'm
17 Lindsey Roth, a senior healthcare analyst at
18 NCQA. And this is Sepheen Byron, Assistant Vice
19 President at NCQA.

20 So the measure that we're presenting
21 today is a health plan measure. And it assesses
22 cervical cancer screening for woman at the

1 population level. It's a long standing HEDIS
2 measure that was first introduced in 1993. And
3 the measure was last reviewed by NQF and endorsed
4 in 2012.

5 And our current measure assesses the
6 proportion of woman ages 21 through 64, who were
7 screened by either cervical cytology in the last
8 three years, or for woman Ages 30 through 64,
9 cervical cytology/HPV co-testing, in the last
10 five years.

11 And since the last endorsement, we
12 updated the measure to align with the 2012 U.S.
13 Preventative Services Task Force recommendations,
14 in which they had added the recommendation for
15 cytology/HPV co-testing every fives, as an
16 option, in addition to the cytology every three
17 years.

18 And our data show that there is room
19 for improvement on this measure. There is a
20 quarter of commercial plan members, and a third
21 of Medicaid plan members, who are not receiving
22 the recommended screenings. And there's also

1 wide variation across health plans.

2 So for example, there's a 14
3 percentage point difference between plans in the
4 10th percentile versus the 90th percentile among
5 commercial plans. And a 27 percentage point
6 difference among Medicaid plans.

7 MS. MUNTHALI: Great, thank you. So
8 I think for this measure, Barry-Lewis Harris was
9 the lead discussant, and of course Emilio, who's
10 on the phone. Emilio, I'm not sure if you're
11 still with us or you're --

12 MEMBER CARRILLO: I'm still with you.
13 I'll be chiming in.

14 MS. MUNTHALI: Okay, great. So,
15 Barry, think it's up to you discuss any points
16 with evidence that you reviewed?

17 MEMBER HARRIS: So I'll say it's quite
18 interesting this being my first meeting and this
19 being the first measure that I have here.
20 Actually be the first person to talk without
21 anyone else having an opportunity to kind of give
22 me a guide. And then the first name is on the

1 phone.

2 So I would like to say that this, my
3 understanding, that this was a maintenance not
4 actually one straight out of the box, is that
5 correct? Because of the --

6 MEMBER CARRILLO: Barry, right now I'm
7 in a place where I can speak, so why don't you
8 let me get started.

9 MS. MUNTHALI: Okay, thank you,
10 Emilio. But you're doing great, Barry.

11 MEMBER HARRIS: Okay. I wanted the
12 baton first.

13 MEMBER CARRILLO: I'm waiting for a
14 taxi, but I think I can get started. Well, this
15 is a maintenance measure and, as has been pointed
16 out, it's a measure that is primarily a health
17 plan measure. It's a great importance.

18 Cervical cancer screening has been
19 shown, repeatedly, to be a very, very valuable
20 preventative measure. And it's something that
21 the health plan follows.

22 And subsequently, we have large amount

1 of information and can compare commercial plan
2 information from Medicaid governmental
3 information.

4 It's a maintenance measure, it's a
5 process measure. And it was first updated in
6 2003. And now we're at the end.

7 And it was first updated in -- it was
8 first implemented in 2003 and then updated in
9 2012. And the impact of the update is not
10 relevant.

11 So I recommend that there's no need to
12 re-discuss the evidence, since that has been done
13 properly before. And this is a maintenance
14 measure.

15 The important consideration of
16 performance gap for a maintenance mentioned, it
17 has been noted. And we do have evidence of a
18 performance gap. Particularly in terms of
19 commercial versus governmental plan.

20 The issue that I think is important
21 for us to discuss is that there is no data
22 stratified by race, ethnicity and language. And

1 this is something that was recommended by the
2 committee in 2012. And is something that should
3 be considered by us.

4 In terms of some other issues, there
5 is some concern, on my part, about the age
6 ranges. It's not clear to me, from what's being
7 presented, why we have a difference in the
8 denominator age range from the measure age range.
9 And I'd like to get some clarification on that.

10 In terms of the measure --

11 MS. MUNTHALI: Emilio? Hi, sorry. We
12 just wanted to talk about evidence right now. I
13 know you mentioned some issues around performance
14 gap and the specifications. And so maybe we can
15 open it up to the committee for any further
16 discussion on evidence only. So then we can have
17 a vote on evidence and then have a discussion on
18 performance gap and the other criterion.

19 MEMBER CARRILLO: Very well.

20 MEMBER HARRIS: So I would like to
21 chime in now, again, Barry-Lewis Harris, to say
22 that I think this is, you know, of course was

1 once one of the most common cancers affecting
2 woman. And now at 14, the number 14, and I think
3 the evidence, again, as he stated, is there that
4 we should definitely keep this in place.

5 MEMBER TEUTSCH: I agree with all of
6 that. Question though is, there's a ginormous
7 over utilization of cervical cancer screening.
8 And I know that's not directly related to this
9 measure.

10 But do we have evidence that they can
11 present on how much over screening there is, the
12 consequences and how that might get incorporated?

13 MS. MUNTHALI: Lindsey or Sepheen?

14 MS. ROTH: Sure. So we don't have
15 data for woman in this age group with respect to
16 overuse. We do have a separate measure that
17 assess non-recommended cervical cancer screening
18 in adolescents, Ages 16 through 20.

19 MEMBER TEUTSCH: And fast, can I ask
20 why the high-risk over 65 are not part of this
21 measure?

22 MS. ROTH: So for this measure, we

1 have it aligned with the USPSTF recommendations
2 for woman in this age group. And this is for
3 commercial and Medicaid plans. And so we do not
4 have a corresponding measure for adults over 64.
5 And I believe also, the recommendation from the
6 USPSTF is not recommended.

7 MS. BYRON: Right. Are you asking why
8 there isn't a measure that looks just at the
9 high-risk?

10 MEMBER TEUTSCH: Right.

11 MS. BYRON: No.

12 MEMBER TEUTSCH: Because, I mean
13 you're probably right, because it's not the
14 Medicare plans. And the Medicare plans should
15 also be looking at woman who had abnormal
16 screens, and considered at high-risk, who should
17 have continued screening.

18 MS. BYRON: Yes. And I'll just also
19 add that specifying in the population, the task
20 force recommendation notes a number of things
21 that would be very difficult to specify, so you
22 would have to be looking for a prior Pap test,

1 the results, whether or not you were foreign-born
2 from certain countries and that sort of thing.

3 MEMBER TEUTSCH: I'd just point out
4 that that's true, but the highest risk are the
5 people who ain't never got screened or the woman
6 who had abnormal screens as opposed to people who
7 have been very good about having their routine
8 screening. So it's the group of perhaps greatest
9 interests.

10 MS. BYRON: I think it's something we
11 can take into consideration. So thank you.

12 MEMBER BIALEK: Just a quick question.
13 Where in the measure is it specified which plans?
14 So you said it's Medicare and --

15 MEMBER TEUTSCH: Medicaid.

16 MEMBER BIALEK: I'm sorry, Medicaid
17 and commercial. Sorry. So where, I haven't
18 found that in the measure itself on the
19 worksheet?

20 MS. ROTH: So just to clarify, the
21 worksheet includes the measure specifications,
22 but with respect to how it's reported to us,

1 plans, if they're a commercial plan, would report
2 their data to us and we analyze it. Or if
3 they're a Medicaid plan they report their data to
4 us and analyze it.

5 And I believe in the worksheet, under
6 the performance data, we have broken out the
7 commercial rates versus the Medicaid rates.

8 MEMBER BIALEK: Thank you. So just a
9 question for staff. As reviewers, how do we know
10 what the measures are meant to be? Who are they
11 meant to be used for?

12 Because often, when you look at the
13 measures, the generic measure of X to do Y. But
14 then when you look at the evidence, it's
15 difficult to match the evidence with the
16 population --

17 DR. NISHIMI: If you look under, on
18 the measure information sheet, there's blue text
19 at the top. And the third cell down says,
20 measure type process, data source and then it
21 says level of analysis. That tells you the level
22 of analysis that the developer is seeking

1 endorsement for.

2 So for instance, they're not seeking
3 endorsement for hospital's data. Because they
4 have been tested in data.

5 Someone else might have a slightly
6 different set of specifications for a measure,
7 but they're only seeking it because they tested
8 it in these systems.

9 MEMBER BIALEK: Thank you, that's
10 quite helpful. I always looked at level of
11 analysis being the analysis done and the data
12 that were provider, not the specification for the
13 measures and that's really helpful.

14 DR. NISHIMI: Yes.

15 MEMBER BIALEK: Thank you.

16 MEMBER HARRIS: So I have a question
17 related to the same performance gap. When you
18 say the commercial plans were 77 percent and
19 Medicaid plans were 66 percent, are you saying
20 that those particular plans were those who
21 actually were in compliance with actually doing
22 this?

1 MS. ROTH: So that indicates that is
2 the average performance rate among the plans that
3 reported their data to HEDIS, to NCQA. So across
4 200 and some plans in the country --

5 MEMBER CARRILLO: I'm signing off.

6 MS. ROTH: -- the average is 77
7 percent for Medicare and 66 percent for the
8 Medicaid plans.

9 MS. MUNTHALI: Okay, are there any
10 other questions with regards to evidence? And
11 one of the things we forgot to say is that if
12 you'd like to make a comment or have a question,
13 if you can turn up your tents just like this. I
14 think it will be easier for Tom and I to manage.

15 So because this is a maintenance
16 measure, and as you remember from our intro and
17 today, and the new evidence that NCQA has
18 presented is directionally the same as the
19 evidence that they have provided when it was last
20 reviewed, the committee can opt just accept the
21 evidence, as in the past, and just not vote on
22 it. So wanted to pose that question for you to

1 see if you wanted to re-vote or just accept the
2 evidence as it was last accepted and the changes
3 that were directionally the same?

4 And just a yes/no is fine. Or a
5 second. You seconded? Okay. If no one objects
6 to that? Okay, so we'll go to performance gaps.
7 So we will just carry over the votes from last
8 time.

9 So Barry-Lewis or Emilio, can you lead
10 us in discussion on performance gap?

11 MEMBER HARRIS: So Emilio has signed
12 off. So we are, just to make sure that I was
13 listening correctly, so we're sort of talking
14 about performance gap in the evidence section.

15 And one of the questions that was just
16 answered was related to how well the systems were
17 actually doing. And so we've gotten that
18 clarified, at least from my perspective, as far
19 as, is there any work that's being done to try to
20 help or will this measure actually help us close
21 the gap, is that what the intent is for this
22 particular measure?

1 I know that we were talking about
2 overutilization by Steve a moment ago, but
3 wondering whether or not we were thinking that we
4 needed a greater emphasis on those who were in
5 their appropriate age group. That was one thing
6 I read about the measure only being started at
7 Age 24 versus 21. Is that a gap that we also
8 need to look at?

9 MS. ROTH: Okay. Yes, so I just
10 wanted to start by clarifying the age group in
11 the measure. So the measure actually assesses
12 whether woman Ages 21 through 64 received
13 cervical cancer screening. But the denominator
14 is specified to start at Age 24.

15 And this is because there's a three
16 year look at period where we're assessing whether
17 woman had cytology performed between Ages 21
18 through 24. And we also specify it to start at
19 Age 24 because we don't want to capture the
20 screenings performed before Age 21 since those
21 are not recommended.

22 So this is really just a measure

1 specification issue with the measure.

2 MEMBER HARRIS: And one of the things
3 that was mentioned in the document, or in this
4 particular measure, was related to whether or not
5 there was disparities there as it relates to
6 this. And one of the things I saw that said it,
7 this was a population health, or you were not
8 looking at different types of groups when you
9 actually did this measure, is that right?

10 MS. ROTH: Correct. Yes. And just to
11 respond to the question about disparities as
12 well. So obviously we do stratify the data by
13 type of insurance, such as commercial versus
14 Medicaid, but we don't currently collect through
15 HEDIS, performance data that's stratified by
16 race, ethnicity and language.

17 But this doesn't stop health plans
18 from actually stratifying data in that way. And
19 we do know that many healths in fact do do that.
20 We just don't have access to that data.

21 MS. MUNTHALI: Arjun?

22 MEMBER VENKATESH: Thanks. I guess I

1 have one comment, and the other is just an
2 informational question.

3 The informational question is, that
4 under performance gap in the sheet we were given,
5 for Medicaid it says the mean is 60 percent but
6 the 10th to 90th percentile is 68 to 73. So
7 those numbers, I guess is that the 10th
8 percentile number is wrong?

9 MS. MUNTHALI: It's a typo.

10 MEMBER VENKATESH: It's probably 48
11 percent, looking at the other years, is that
12 right?

13 MS. MUNTHALI: Yes, that's right.

14 MEMBER VENKATESH: Okay.

15 MS. ROTH: Are you -- I believe it's
16 on Page 16?

17 MEMBER VENKATESH: I'm on Page 3 of
18 34.

19 DR. NISHIMI: Yes, the mean is -- for
20 the Medicaid rate?

21 MEMBER VENKATESH: Medicaid mean, 2000
22 --

1 DR. NISHIMI: Is 60 percent.

2 MEMBER VENKATESH: And then the --

3 DR. NISHIMI: The 10th is --

4 MEMBER VENKATESH: -- 10th and 90th
5 is?

6 DR. NISHIMI: Fifty-four to --

7 MS. ROTH: It's 46.

8 DR. NISHIMI: -- 43. Oh, I'm sorry,
9 46 to 73.

10 MEMBER VENKATESH: Okay.

11 DR. NISHIMI: That table.

12 MEMBER VENKATESH: It's a typo. All
13 right. So my comment is this. I guess, when I
14 look at these numbers, on the commercial side, I
15 see performance rates that have largely not
16 changed over three years. That is not to say
17 that that means the measure is in, you know,
18 automatically flawed, but to me that brings up
19 three questions.

20 One is, is it possible that because
21 these measures are specified in administrative
22 claims, we don't capture everything we would want

1 in a perfect measure and this measure is actually
2 already topped out? Meaning, that this is as
3 good as performance as it's going to get and
4 there's not much additional diet in the measure.

5 Or second, does it mean the measure is
6 not exactly measuring what we want it to? That
7 it's not able to directly measure screening for
8 cervical cancer in the way we intend and that's
9 why you see the same number every year?

10 And then I guess the sort of related
11 question to that is, this disparity between the
12 Medicaid rates and the commercial rates, is that
13 a disparity?

14 And if it is, then I think this speaks
15 to why this measure is important and why it needs
16 to remain or is that just simply a function of
17 the fact that there's more turn in Medicaid plans
18 and as a result, they're not capturing at the
19 same rate, data elements that you would capture
20 in the commercial measure, and that's why that
21 also is similarly kind of flat, but just
22 translated down the curve a little bit?

1 And so the reason I ask these
2 questions is because we're about three years in,
3 we should ask whether or not there is value in
4 continuing the work of the measure, having the
5 measure and doing this measure. And it's
6 possible, three years from now, all these numbers
7 could improve. And we'd look back and it doesn't
8 say, yes, this is worth all the effort and
9 burden. But if not, I'm just wondering if we're
10 just not getting anything out of the mission.

11 MEMBER SALIVE: I think this one is
12 worth keeping. I mean, as was stated by the
13 primary reviewer, the long-term trend is very
14 positive on, I think, prevention of cervical
15 cancer.

16 So whatever happened in three years,
17 you know, we can speculate on that. But it still
18 needs to be continued.

19 MEMBER STIEFEL: I probably only need
20 to ask this once, as a new member. Because I
21 have a feeling it will come up a lot.

22 So race, ethnicity, language are

1 obviously important for a measure like this.

2 NCQA and HEDIS don't have access to that

3 information.

4 So I guess the question, what's the

5 role of NQF here? It looks like it was

6 recommended last time the measure was reviewed.

7 Do we just have a sort of generic

8 recommendation that would be really good to have

9 race, ethnicity and language data recorded in

10 HEDIS? So I'm not sure where, what the

11 committee's role is here.

12 MS. MUNTHALI: Yes, this was a topic

13 of discussion last time around. And I'll ask

14 Robyn to chime in as well.

15 You know, the developer is constrained

16 by what they can get in terms of the data. There

17 was a very strong recommendation that the

18 developer try and find a mechanism to be able to

19 assess across populations and see differences

20 across populations. And it will be good to hear

21 perhaps what the progress has been since then.

22 MS. BYRON: Yes, thank for you

1 bringing -- I mean, it is a very important point
2 and we do understand that. And it's something we
3 are exploring for the future in terms of how we
4 can get data.

5 We do have two measures within HEDIS
6 that look at race, ethnicity, diversity of
7 membership. And another one looking at language
8 diversity of membership.

9 So it is something that we have looked
10 into for a while. And we've explored how to
11 really encourage and culturally and
12 linguistically appropriate services through other
13 means.

14 We have a multi-cultural healthcare
15 distinction program that health plans can look at
16 that really layout the standards that you should
17 be meeting to be able to provide culture and
18 linguistically appropriate services.

19 So that includes things like
20 collecting data for race/ethnicity. Making sure
21 you have network adequacy. You know, making sure
22 that you understand the needs of your population.

1 Race/ethnicity, those types of
2 disparities, we have heard from health plans,
3 it's very specific to certain regions and areas
4 and plans. So what we're balancing is the
5 importance of whether or not they should be
6 reporting that information to NCQA so that we can
7 show the averages or whether it's something that
8 they should be doing within their own area and
9 slicing the data in the ways that they can, using
10 their enrollment information. So should they
11 look at race/ethnicity?

12 And then also look at gender, age.
13 And we have found that health plans, because they
14 are motivated to improve their rates, are
15 motivated to look at the data in that way.

16 That said, we do understand it's
17 important and it is something that we want to
18 explore for HEDIS, and that we're continuing to
19 do.

20 But through those measures that are in
21 HEDIS now, we can see that a lot of plans, even
22 the ones who are very far ahead of the curve, are

1 still not reporting that they have complete data
2 around race and ethnicity. And there are a
3 number of ways they can be getting it that they
4 are still exploring.

5 You know, whether they should be
6 getting it through indirect means, such as zip
7 code analysis, or whether they can get it
8 directly from CMS.

9 And so those are things that are in
10 the works for us. And we've been working
11 actually with the CMS Office of Minority Health
12 to explore how to continue to do quality and
13 measurement in vulnerable populations. That that
14 includes race/ethnicity, people who have limited
15 English proficiency, sexual minorities and that
16 sort of thing.

17 MEMBER STIEFEL: Is it appropriate for
18 NQF to make such a recommendation? If it --

19 MS. MUNTHALI: So it would be the
20 committee doing it on NQF's behalf. So if you
21 think that it is a strong preference or you want
22 to, let's say an annual update at the next

1 maintenance review, see those data and see the
2 measure at least stratified or looked at by those
3 different sub-populations, that is appropriate.

4 Steve?

5 MEMBER TEUTSCH: Two points. One to
6 follow on to what Matt's saying. Maybe the most
7 important, sociodemographic variables, are things
8 like education, income, other kinds of things.

9 And then in terms of actually
10 improving these measures and allowing plans and
11 other statutes, a lot of them do something about
12 them. Many of those measures should be collected
13 as well. I know that's a reach, and it's not
14 specific to the cervical cancer measurement, but
15 in general we need something richer than
16 race/ethnicity.

17 And I know that you talked about some
18 of them, like culturally, in appropriate
19 communications and things like that. But it was
20 a much broader set of things that are really
21 important.

22 To Arjun's point, and someone can

1 correct me because this is coming out of my
2 memory, there are roughly 4,000 deaths a year
3 from cervical cancer. It's my recollection
4 that's the same number there was in 1980.

5 And you can correct me if I'm wrong on
6 that, but --

7 DR. NISHIMI: Deaths.

8 MEMBER TEUTSCH: Deaths, right?
9 Roughly. Which would suggest that we haven't
10 made a huge amount of improvement.

11 And I think it's partly because of
12 some of the issues we've been talking about here
13 which is, you know, some people get screened
14 pretty religiously and then there is a cohort,
15 many of whom are actually not in reality, healthy
16 systems that you're measuring, who are not get
17 the necessary services.

18 So it's not really a reflection of
19 this measure and how much these plans are doing
20 things, but sometimes I think we are looking
21 under the light post when the problem is
22 elsewhere.

1 MS. MUNTHALI: Patricia? Barry?

2 (Laughter.)

3 MEMBER HILL: Oh, I'm happy to speak
4 up, because we talked about this the last time I
5 was here. And I would like to say that the
6 committee, I think, is interested in seeing the
7 measure developers take some lead.

8 I understand there will be questions,
9 at a systems level, as to who it's most useful
10 to. But somebody has to step out there and take
11 the lead. And we'd love to see the measure
12 developers do that consistently.

13 I dream of a time when we meet and we
14 don't have to bring up the issues of disparities
15 and parsing our data sufficiently enough to
16 address all American needs in health.

17 MEMBER HARRIS: I was just going to
18 actually just bring up the additional point that
19 looking at the race/ethnicity is nice as well,
20 but I think looking at the other areas that was
21 mentioned, mostly related to education as well as
22 demographical variances or differences, because

1 it is 4,120, I think, is the estimated amount.

2 So it's the same number that he
3 stated, but I think that, you know, are we really
4 looking at the population that needs the greatest
5 impact or are you just looking at the same
6 population that we've always looked at for
7 several years?

8 MEMBER McKANE: Okay, I was just going
9 to say that with many of our metrics that we look
10 at in public health, often race/ethnicity, we do
11 see racial/ethnic disparities. And when we do
12 call control for economical education, the
13 disparities remain. So I think that that is
14 very, very important.

15 And I also fully appreciate that with
16 claims data or electronic data, that it can be
17 difficult to capture race and ethnicity
18 accurately. You know, ideally it's a self-
19 report, but it may or may not be. And people
20 have the right to refuse to give that
21 information.

22 So I think also, I remember one

1 measure I reviewed they did, you know, there was
2 a 13 percent missing on the race/ethnicity
3 variable, which could skew your results. But I
4 would echo and encourage that that analysis be
5 done.

6 MS. MUNTHALI: Ron?

7 MEMBER BIALEK: I'm just wondering if
8 NQF, at some point, can add to its criteria for
9 maintenance measures, presenting data from
10 national data, it could be from BRFSS or other
11 sources, that during that period of time, when
12 the measure was in effect, potential
13 consequences. And it could be unintended
14 consequences.

15 So you can remain at 4,000, but you
16 can be improving with one population and
17 declining for another. And I think it's
18 difficult for us, in a maintenance measure, to
19 say, go forth with the maintenance measure
20 without having any of the national data of what
21 impact, nationally, or what unintended
22 consequences could there have been as a result of

1 the measure.

2 So I don't know if NQF has that in the
3 criteria that the measure developers are to
4 present other data that can be national,
5 generalizable data, to suggest what's going on
6 within that particular health condition.

7 DR. NISHIMI: That's actually one of
8 the intents of the disparities question. The
9 developer does have the option to present non-
10 performance measure.

11 The preferred obviously though, as
12 NCQA put it, which is the performance data based
13 on their measure.

14 A question for them though. You
15 indicated that health plans are using this
16 measure, obviously, and collecting it on their
17 own. Is it possible for you to work with some of
18 your health plan to anonymize and just bring back
19 to the committee some of the disparities findings
20 they are having, you know, perhaps in an annual
21 maintenance? Certainly by the next full
22 maintenance.

1 Because this is four years now and we
2 still have no disparities data. So I think you
3 can hear a little bit of the frustration from the
4 committee on not having the data.

5 And if you can either look at the
6 literature or work with your health plans, I
7 think that would probably go a long way to
8 helping the committee out. I see nods around the
9 head.

10 CHAIR MCINERNEY: I know that many
11 physicians are reluctant to record race and
12 ethnicity in their electronic health records or
13 their paper records anywhere, and so that must
14 make it very difficult for NCQA to get
15 race/ethnicity data. Do you have, in general, do
16 you know what percent of physicians are recording
17 race and ethnicity and can you at least give us a
18 feeling for that please?

19 MS. BYRON: Yes. I think it's
20 changing. We looked at a health plan level, but
21 obviously the health plans are pulling from
22 physicians and others.

1 The last time I looked, but that was
2 a while ago, you know, like I said, the leading
3 health plans who were actually putting a lot of
4 effort into this area, maybe had race/ethnicity
5 data on about 30 percent of their population.
6 This was a little while ago. I think it's
7 probably, hopefully, a little bit better.

8 But, you know, there are issues with
9 ONC requiring the race/ethnicity variables for
10 meaningful use that I think is going to be
11 helping things to be more standardized. You
12 know, just agreeing on the types of categories
13 one should be using.

14 That's always been a back and forth
15 because some people want to collect very detailed
16 information based on the area in which they
17 reside. So there has been issues rolling up to
18 the same aggregate categories. So even when you
19 have the data, sometimes it's not very useable.

20 When we looked at our race/ethnicity
21 variable in HEDIS, we saw that many plans were
22 reporting unknown or refused. And I think

1 there's probably a lot of that still going on.

2 MS. MUNTHALI: Other questions? Okay,
3 I think we're -- oops.

4 DR. NISHIMI: I was just going to say,
5 I think we're ready to vote, but I just want to
6 confirm with the meeting that we do want to make
7 a recommendation to the developer to try and work
8 with some of their members who are perhaps
9 collecting and have a better feel front line. So
10 that the next time you look at this measure you
11 will have some kind of -- so we'll do that for
12 you, okay.

13 MEMBER HARRIS: So do we need to
14 separately vote it or --

15 DR. NISHIMI: No. I just wanted to
16 confirm by looking at it.

17 MS. MUNTHALI: It would go as part of
18 your final recommendation in the report.

19 Okay, so before we actually go through
20 the vote we'll have Yetunde go through an example
21 or show us how to do it.

22 MS. OGUNGBEMI: So I'm going to give

1 you instructions on how to vote. When voting,
2 please use your blue remote control. Everyone
3 should have one. If you do not, please see
4 Sheila or raise your hand and she can give you
5 one.

6 Only press the voting options that are
7 made available to you. So it will usually be
8 voting options one through four. And sometimes
9 it will be one or two. Sometimes it will only be
10 one, two or three.

11 Point towards my colleague Sheila and
12 Diane over there beside the windows when you are
13 voting because they have the software to capture
14 your votes. If you change your vote while the
15 voting is still open, it will only capture your
16 last vote.

17 So if you press 1 and you meant 2, you
18 can press 2, while the voting is still open. If
19 you have any technical difficulties, please raise
20 your hand immediately so we can attend to you
21 then.

22 I will be proxy voting for Michael

1 Baer and Emilio, once he joins us again. Those
2 are the participants of the committee that are on
3 the phone. They will be submitting their votes
4 confidentially via the chat option on the web
5 platform.

6 And if you have any questions, please
7 let me know. Okay.

8 MS. MUNTHALI: So we're going to be
9 voting on performance gap. Oh, you want to do a
10 test? Let's do a test. So we'll do a test on
11 evidence. We're going to do a test on evidence.

12 As you remember, we decided not to re-
13 vote but we just want to see, make sure you
14 captured the instructions and your clickers are
15 working. So I will turn it over to -- Sheila,
16 are you going to queue us up?

17 MS. CRAWFORD: Sure. Go ahead and
18 vote. We currently are looking for 14 votes
19 until Emilio gets back on the phone. So once the
20 polling responses reaches 14, then we'll know we
21 have captured everything.

22 Is a number coming up?

1 Oh, it's fine. Once you've put your
2 number in, yes, you should only have to do it
3 once. We just need three more.

4 (Simultaneous speaking.)

5 MS. CRAWFORD: It is. No, no, at the
6 top. It needs to warmup. So at the top, where
7 it says responses, we have 12. But says polling
8 open, so we need two more.

9 MS. MUNTHALI: You don't see it,
10 typically you see it on the screen, you're not
11 seeing it now.

12 MS. OGUNGBEMI: Can everyone point
13 again? What are we at?

14 MS. CRAWFORD: Twelve. Yetunde, did
15 you point --

16 MS. OGUNGBEMI: Yes. Oh, just for
17 testing.

18 MS. CRAWFORD: For testing.

19 (Laughter.)

20 MS. MUNTHALI: So what are we at now?

21 MS. CRAWFORD: Still at 12. Thirteen.
22 One more. Towards this laptop.

1 MS. MUNTHALI: Should be 14.

2 MS. CRAWFORD: Oh, maybe that's the
3 issue.

4 MS. MUNTHALI: Oh.

5 MS. CRAWFORD: Okay, then we're good
6 to go. Okay, we have our 14. Okay. Polling is
7 closed.

8 And this is what it will look like.
9 Thirteen voted yes, one voted no. And our
10 percentage for each of that. So our clickers are
11 working fine. We are good to go in terms of
12 voting.

13 MS. OGUNGBEMI: Yes, so this is for
14 real.

15 MS. CRAWFORD: This is for real.

16 MS. MUNTHALI: Okay, so the committee
17 will be voting on performance gap for Measure
18 0032: Cervical Cancer Screening. This is a
19 maintenance measure submitted by NCQA.

20 And the options are, 1 for high, 2 for
21 moderate, 3 for low and, 4 for insufficient.

22 MS. OGUNGBEMI: Polling is open.

1 MS. MUNTHALI: Polling is open. Okay,
2 we have 13 votes. That's the final. And the
3 measure passes performance gap with one high
4 vote, 11 moderate vote, one low vote. And the
5 percentage, which will be shown very shortly, is
6 85 percent pass, with a moderate, and eight
7 percent high and eight percent low. So we can
8 proceed to reliability.

9 MEMBER HARRIS: So hopefully, Barry-
10 Lewis Harris, hopefully reliability conversation
11 will be very short because I think it seemed to
12 be that the reliability was very high from what I
13 read. I didn't see any evidence that it showed
14 that the reliability was low.

15 MS. MUNTHALI: Are there any other
16 comments? And as with evidence, reliability
17 hasn't changed since the measure was last looked
18 at. The committee can opt to not re-vote and
19 just accept the previous decision from the last
20 maintenance review. And I'm seeing nods saying
21 yes. So we'll proceed to validity. Barry-Lewis?

22 MEMBER HARRIS: So the validity

1 testing, the actual threats to validity testing
2 was related to the different measures. Whether
3 the patient had a hysterectomy or no residual
4 cervix or absence there.

5 The risk adjustment was actually none
6 that I think I read about. And there were
7 different numbers that were relating to
8 meaningful difference of the commercial versus
9 Medicaid families we discussed previously, a
10 little bit before, I think.

11 And this particular evidence, I mean
12 this particular measure, wanted to ask the
13 developers whether or not they had any new
14 information about maybe moving this one way or
15 the other in improving the threats to the
16 validity or if you feel that this is the best
17 that we would have?

18 MS. ROTH: So I think we feel
19 comfortable that there are no significant threats
20 to validity for this measure. I also wanted to
21 add that we, you had mentioned the exclusion for
22 absence of cervix or total hysterectomy, and NCQA

1 does have a Policy Clarification System in which
2 we take questions from health plans about the
3 measure and respond to health plan questions.

4 And for this particular measure, we
5 have not noted any questions that we've received
6 that would make us question validity.

7 MS. MUNTHALI: Are there other
8 questions? There was a, we were reviewing the
9 committee's comments, and there was a question
10 about the t-score.

11 And so there was some comments, also
12 from staff, about the significance of that t-test
13 to the measure score and how it was able to
14 distinguish poor from high quality.

15 MS. ROTH: I can respond to that and
16 provide a little more information. So this
17 particular test we had determined the P value of
18 an independent samples t-test and we compared
19 commercial plans in the 20th percentile to the
20 commercial plans at the 75th percentile. And
21 what the P value of that shows, if it's less than
22 .05, than the two groups performance is

1 significantly different from each other.

2 And so this is just another way of
3 demonstrating that there is meaningful
4 differences in performance across the health
5 plans.

6 And so we did this for commercial
7 plans. The P value was less than .05. And the
8 same with the Medicaid plans, it was also less
9 than .05.

10 MS. MUNTHALI: Okay, are there any
11 other questions? Robyn, did you --

12 DR. NISHIMI: No. The staff
13 recommendation was based on just face validity,
14 but since NCQA has fought for the information on
15 score level, it is eligible for high.

16 So you have three options for
17 validity. Or because I think it's maintenance,
18 you can also just, as with reliability, not vote
19 again. It's really up to you.

20 MEMBER HARRIS: Did you -- I can't, I
21 was looking for it, what was the actual
22 recommendation for the last review?

1 DR. NISHIMI: We didn't have the same

2 --

3 MEMBER HARRIS: Just for the record.

4 DR. NISHIMI: So it was a -- it was
5 valid, it was strong. We didn't have the four-
6 part voting system, but it was judged as valid.
7 And so we would, we could go forward with that.
8 Or you could vote, if you wanted to give it a
9 four-parter.

10 CHAIR McINERNEY: I think the sense of
11 the committee is to vote. Thank you.

12 MS. MUNTHALI: Okay, so just wanted
13 to, as Robyn mentioned, the highest rating this
14 could receive, because it has face validity only,
15 is --

16 DR. NISHIMI: No, they just explained
17 the score.

18 MS. MUNTHALI: Oh, they did?

19 DR. NISHIMI: Yes, the t-test. So
20 it's --

21 MS. MUNTHALI: So, Karen, now we have
22 our methodologist coming here.

1 MS. JOHNSON: Well, I understand that
2 that would actually show, as you mentioned,
3 meaningful difference between plans. That is not
4 usually what we're looking for in terms of score
5 level validation. So I would still say that
6 you'd be looking at the face of validity for
7 this.

8 MS. MUNTHALI: So you will be looking
9 at face validity. The highest it can receive is
10 a moderate. This is a two.

11 So the clicker, the options have
12 changed. So, 2 for moderate, 3 for low, 4 for
13 insufficient. And so voting is open. Sheila,
14 how many votes? One more vote?

15 MS. CRAWFORD: We have 13.

16 MS. MUNTHALI: Okay.

17 MS. CRAWFORD: That's what we're
18 looking for now, right?

19 CHAIR McINERNEY: There we go. Now we
20 got it.

21 MS. MUNTHALI: Thirteen, okay. Okay,
22 so this is not right. It didn't look right. So

1 let's do this again because what, for those on
2 the phone --

3 Yes. So remember 2, 1 is not an
4 option. One is not an option. Two is moderate,
5 3 is low, and 4 is insufficient.

6 So for those on the phone, all of the
7 votes were low, we knew that wasn't right.
8 Because they did meet, face validity.

9 (Simultaneous speaking.)

10 MS. MUNTHALI: You all hit 2?

11 (Simultaneous speaking.)

12 MS. MUNTHALI: So let's do a hand vote
13 for this one.

14 MS. CRAWFORD: Yes.

15 MS. MUNTHALI: So if you can raise, if
16 you're voting moderate can you raise your hand?

17 MS. CRAWFORD: Thirteen.

18 MS. MUNTHALI: Thirteen. It's
19 unanimous. Moderate.

20 MS. CRAWFORD: Okay. Yes.

21 MS. MUNTHALI: Yes. So we'll look at
22 that. Yes.

1 MS. CRAWFORD: Okay.

2 MS. MUNTHALI: So we'll move on to
3 feasibility.

4 MEMBER HARRIS: So with feasibility,
5 which is the extent to which it could be
6 measured, the rating, I guess the preliminary
7 rating, is related to moderate. And so could we
8 have a little bit more information related to the
9 concerns that were brought up by the staff? As
10 to why this wouldn't be high versus moderate.

11 MS. MUNTHALI: Yes, I think part of
12 the concerns was some of the data was out of E,
13 or an electronic sources and they weren't defined
14 fields. I think that was part of the feasibility
15 concern that was raised. Robyn, did you want to
16 speak to it?

17 DR. NISHIMI: Yes. It just said, so
18 we quoted from the submission. It said sum data
19 as opposed to all data. So that's why it went
20 from high to, in the staff's opinion.

21 MEMBER HARRIS: And green, I'm not
22 sure what that -- okay, great. More than three

1 people. What about the fact that someone had
2 decoded, other than it actually being
3 automatically put into the system?

4 DR. NISHIMI: That could be. I can
5 just speak to what I would have indicated.
6 That's often the case --

7 MEMBER HARRIS: Okay.

8 DR. NISHIMI: -- with administrative
9 data. So that's taken as a given. But it was
10 the sum data that was of higher concern.

11 MS. MUNTHALI: Any other concerns or
12 questions for NCQA?

13 DR. NISHIMI: I just wanted to say,
14 that's something that you're free, of course, to
15 take into account though. The translation issue.

16 MS. MUNTHALI: So just a reminder,
17 feasibility is not must pass. It is very
18 important for us think about when we're thinking
19 about maintenance measures or any new measures
20 that come forward.

21 So the options, again, are 1 high, 2
22 moderate, 3 low and 4 insufficient. Voting is

1 open.

2 All right. So it looks like we're at
3 13. And so four voted high, nine voted moderate.
4 And so this measure, 0032, passes on feasibility.

5 So we will now vote on usability and
6 use. And, Barry-Lewis, any comments?

7 MEMBER HARRIS: Just a question for
8 the committee, was related to whether or not it
9 could be used, further goal of high quality and
10 efficient care.

11 And the rating I see, preliminary was
12 high, even though we did have a conversation
13 related to only testing those commercial and
14 Medicaid plans without actually looking at
15 populations that are more higher risk. So for
16 those populations that we actually are looking
17 at, it would be a good high rating I would say.

18 DR. NISHIMI: Arjun raised the
19 question about usability and use in the context
20 of evidence and whether it got taught. But it's
21 probably relevant to discuss here. Did you want
22 to go over that, Arjun?

1 MEMBER VENKATESH: Sure. I mean, I
2 think there's a tremendous amount of interest in
3 the measure and a lot of people want to use it.
4 That's the evidence that you see of all the
5 accountability programs.

6 The measures used within it gets rated
7 by the MAP, that this should be included in other
8 programs.

9 And so that is what I feel like you
10 have to balance with that table that basically
11 shows the last three years' performance. And the
12 mean doesn't change, the IQR doesn't change. And
13 there's essentially been no change in
14 performance.

15 Like it's really rare to see that
16 little of change in a performance in a measure
17 over three years. And so I'm going to probably
18 rate this moderate.

19 And the reason being that, on one hand
20 I see a measure that has a lot of conceptual
21 interest in use and active use in programs, but
22 on the flip side, I don't see really any evidence

1 that, since it was originally endorsed, that
2 there's been any action on it.

3 Now if you could say, hey, there are,
4 this measure was used during these quality
5 collaboratives and there was improvement there.
6 Like some evidence that somebody got better when
7 this measure was used, I think that that would
8 improve the usability rating. But that's just
9 not there within the current presentation.

10 MS. MUNTHALI: Marcel?

11 MEMBER SALIVE: So my only concern on
12 this is really, I think what Steve mentioned
13 earlier, that there's sort of an over testing
14 that's done like by a lot of people in practice.
15 And I think that this measure doesn't really deal
16 with it, and so it gives me that concern.

17 And I believe that that is done, you
18 know, individually, by practitioners and
19 anecdotal quite a lot. So this has no breaks
20 on it. It just looks at the use.

21 MS. MUNTHALI: Any other comments?

22 Okay, we will vote on usability and use for

1 measure 0032. High is 1, 2 for moderate, 3 for
2 low and 4 for insufficient information.

3 Okay, 11 voted moderate and two voted
4 low. So this measure passes, usability and use.
5 And so we'll go to overall suitability for
6 endorsement.

7 Okay, any last comments on anything
8 that we've discussed before, before we vote on
9 the overall suitability for endorsement? Okay,
10 no comments.

11 One, yes, 2 no. Voting is open.
12 Okay, two unanimous, 13 voted yes. Measure 0032
13 is recommended for endorsement.

14 Thank you, you guys did really well.
15 It typically takes about 90 minutes for a
16 committee to do the first measure, you were well
17 under 90 minutes, so we will give you a 15-minute
18 break. We can come back at 10:35.

19 CHAIR McINERNEY: No, I just have one
20 question for the measure developers. Would it be
21 possible, going into the future, to correlate
22 with HPV vaccine status?

1 Because I'm just wondering if some
2 women who say, you know, I've had the three HPV
3 vaccines and I prefer not to do the Pap smear,
4 would that affect your results?

5 MS. BYRON: Yes, I think that's
6 something that we can look into. It's
7 interesting.

8 The HPV measure is for adolescents up
9 to Age 13 though. So we might have to look at a
10 different data search. I'm just thinking about
11 how we would do that.

12 Because cervical cancer is a different
13 age group. But we could still look to see if the
14 measures are correlating. So that's interesting.

15 MEMBER HARRIS: I would just like to
16 say, well, two things. One, to tag what Tom is
17 saying.

18 The HPV vaccine and the measurement of
19 HPV is supposed to, not the vaccine, but just
20 measuring for HPV is supposed to lengthen the
21 time. So you go from three to five.

22 So I think that's the point that was

1 being made is that if you're doing the HPV
2 screening and then you're getting a negative
3 result, then you say, hey, well there is more
4 time available to not actually have to screen.
5 And so that's what, I think, the question is.
6 Are we looking at that, not necessarily the
7 vaccine for the adolescent age?

8 Second, Elisa, first time out of the
9 box, so there you go. That's the 90 minutes.

10 MS. MUNTHALI: You did great. You did
11 great. Thank you. So we'll be back at 10:35.

12 (Whereupon, the above-entitled matter
13 went off the record at 10:19 a.m. and resumed at
14 10:35 a.m.)

15 CHAIR McINERNEY: Thanks everyone for
16 reporting back promptly after the break. I
17 believe, Michael Baer, are you on the line now?

18 OPERATOR: He is not.

19 CHAIR McINERNEY: He's not. Okay. And
20 how about Emilio, are you back? Are you here or
21 are you on the line?

22 (Laughter.)

1 CHAIR MCINERNEY: Neither, okay. On
2 route hopefully. Okay, so we're ready to go with
3 the next measure please.

4 MS. MUNTHALI: And before we do that,
5 Katie, I don't know if you were here when we went
6 through and did introductions and disclosures --

7 MEMBER SELLERS: Yes.

8 MS. MUNTHALI: You did? Okay, great.
9 So we just wanted to announce again that we will
10 soon talk about the, we're talking about the
11 childhood immunization measure right now, but
12 Robyn will be recused from every measure after
13 this, so she will not be participating in any
14 discussion.

15 When the measure that she was involved
16 in comes up, she will actually leave the room.
17 And that is per our disclosure of interest policy
18 that applies to, not just committee members,
19 developers, but also to staff and consultants.
20 Robyn?

21 DR. NISHIMI: I'm just going to
22 actually leave as soon as immunization starts.

1 But I'll be back after mine comes up, which is
2 the dialysis one, so.

3 MS. MUNTHALI: So our next measure to
4 review is measure 0038, this is Childhood
5 Immunization Status. This is also stewarded by
6 NCQA. And we'll turn it over to NCQA, maybe
7 Mary, can you introduce yourself?

8 DR. BARTON: Sure. Thanks very much.
9 This is Mary Barton, I'm Vice President for
10 performance measurement at NCQA. And Sepheen
11 Byron is going to introduce the measure.

12 MS. BYRON: All right. So this is
13 another health plan measure in HEDIS. It's a
14 longstanding HEDIS measure that looks at the
15 percentage of children who receive their
16 recommended vaccinations by the age of 2, and it
17 applies to commercial and Medicaid health plans.

18 It's also a measure that's widely used
19 in programs such as the Medicaid Child Core Set.
20 We use it in our health plan accreditation
21 programs as well, and it's based on the guideline
22 from the Advisory Committee on Immunization

1 Practices.

2 MS. MUNTHALI: Great, thank you. So
3 Tom and Katie, you are the lead discussants. I'm
4 not sure who would like to start.

5 CHAIR McINERNY: Katie, why don't you
6 go ahead first, please, if you don't mind. Thank
7 you.

8 MEMBER SELLERS: Okay, sure. So let's
9 see, the developers gave the measure number and
10 title. This is the percentage of children 2
11 years of age who have had four diphtheria,
12 tetanus, pertussis, DTaP, three polio, one
13 measles, mumps and rubella, three Hib, three Hep
14 B, one chicken pox, four pneumococcal, one Hep A,
15 two or three rotavirus and two influenza vaccines
16 by their second birthday.

17 CHAIR McINERNY: And a partridge in a
18 pear tree.

19 MEMBER SELLERS: Yes. And the measure
20 calculates a rate for each vaccine as well as a
21 combination rate. The numerator statement is
22 children who receive the recommended vaccines by

1 their second birthday.

2 The denominator statement is children
3 who turn 2 years of age during the measurement
4 year, and the exclusions are children who have
5 had a contraindication for specific vaccine from
6 the denominator for all antigen rates and the
7 combination rates.

8 So the denominator for all the rates
9 must be the same. It's a process measure. The
10 level of analysis is the health plan and the date
11 it comes from administrative claims and
12 electronic critical data.

13 And I think the developer said this,
14 but it was originally endorsed in 2009 and most
15 recently in 2012.

16 So moving on to the evidence. There's
17 a systematic review, a ton of evidence here.
18 There is some updated evidence. Previously they
19 were relying on the 2011 ACIP recommendations and
20 now it's the 2015 recommendations.

21 I guess the one weakness is there's no
22 specific evidence cited for the measurement that

1 combines all ten immunizations. If you go
2 through the evidence algorithm, it basically
3 comes out to be moderate.

4 There's a question for the committee
5 that I wasn't completely sure that I understood.
6 So the question is the developer reports the
7 guideline has been updated, but the 2015 update
8 does not impact the measure and so is consistent
9 with the specifications.

10 DR. NISHIMI: So then the question is
11 the committee can as with the first measure
12 forego voting again.

13 MEMBER SELLERS: Okay. Okay, so does
14 the committee feel that it's okay to forego
15 voting on the evidence based on the consistency
16 of this measure over time.

17 MS. MUNTHALI: Okay, so we'll go to
18 performance gap.

19 MEMBER SELLERS: Okay, so moving on to
20 performance gaps, they provided the data on this
21 for each of the ten vaccines and the combination
22 rate of all ten. When they combine it they show

1 a mean of 47.57 for commercial plans and a mean
2 of 36 for Medicaid.

3 Sorry, I was comparing the years. So
4 an 11 point difference there. The same issue
5 with stratifying by race, ethnicity or language.
6 So then the question for the committee is, is
7 there a gap in care that warrants a national
8 performance measure.

9 MEMBER VENKATESH: I guess I'd just
10 ask a question of the developers here to
11 understand performance on this measure. So the
12 new part of this is the composite part. Is that
13 true?

14 MS. MUNTHALI: No.

15 MEMBER VENKATESH: It's always been
16 there?

17 DR. NISHIMI: No. The composite was
18 previously there. They actually had many more
19 composites.

20 MEMBER VENKATESH: Okay, then I'll
21 hold my question for validity.

22 MS. MUNTHALI: Matt?

1 MEMBER STIEFEL: Can we just make our
2 recommendation about race, ethnicity and language
3 and maybe SES to apply generally to all of these
4 for which it's relevant?

5 MS. MUNTHALI: It's noted. Other
6 questions, recommendations?

7 Okay, even though this is a
8 maintenance measure we still have to vote on
9 performance gap. So 1 high, 2 moderate, 3 low, 4
10 insufficient. Voting is open.

11 Okay, so 11 voted for high, two
12 moderate, so this measure passes on performance
13 gap. And so because this is a composite we need
14 to assess the construct of how the ten components
15 of this measure hang together.

16 So there's a vote on that and
17 discussion first. So Katie and Tom.

18 MEMBER SELLERS: So the discussion
19 questions here are is the quality construct
20 logical combining the ten recommended vaccines,
21 and I would say yes unless anyone has any comment
22 about that.

1 Is inferring the individual ACIP
2 recommendations apply as the rationale for all
3 ten composite appropriate? Again this has been
4 addressed by the committee previously, I believe.
5 I don't know if there are any comments about
6 that.

7 DR. NISHIMI: Actually, the previous
8 forms didn't break out the composite this way, so
9 that's why we do need the committee this time.
10 Even though they had been endorsed --

11 MEMBER SELLERS: I see. This is a
12 change in the NQF procedure even though the
13 measure has not changed.

14 DR. NISHIMI: Right.

15 MEMBER SELLERS: Got it. Okay, so is
16 there any discussion about the appropriateness of
17 combining all ten vaccines?

18 MEMBER HILL: I think there were some
19 discussion previously about it being an all or
20 nothing, being a disincentive for getting, you
21 know, people who were accomplishing 75, 80, 90
22 percent were feeling like they weren't getting

1 credit for what they had done.

2 I don't know if anybody else has heard
3 that feedback. Oh, sorry. Steve.

4 MEMBER TEUTSCH: To circle around that
5 same line, the actual utilization of all these
6 individual vaccines is really, really high and it
7 does look, you know, like the gap is really big,
8 when in fact it's actually relatively modest.
9 And for many of these diseases the rates now of
10 disease are extremely low fortunately. This is
11 obviously one of the great successes.

12 So I'm not against this measure in any
13 way, but it does suggest that you may lose some
14 of the focus on the areas that actually do need
15 improvement, because it does suggest a bigger
16 problem than probably exists.

17 MEMBER HILL: I would agree and that's
18 consistent with the feedback I've gotten. And I
19 think, you know, with a successful measure we
20 have to be willing to kind of drill down and see
21 what within that composite now constitutes the
22 primary gap.

1 MEMBER TEUTSCH: Can I say one more
2 thing sort of along those lines? I guess one
3 could have a measure saying how many kids meet 90
4 percent or more, or 80 percent of more of all
5 these vaccines. Perfection is pretty hard to
6 achieve.

7 And while I'm not suggesting any one
8 of these should be removed from the list, there
9 are some that, you know, are tough. And I also
10 worry, frankly, about the immunization measures
11 that the biggest problem is people who opt out
12 right now, and it's become a bigger problem in
13 oftentimes in the communities you think should
14 know better.

15 But that's not really addressed in
16 here, which is what's really, in addition to
17 getting those who aren't getting them for
18 whatever clinical reason you have this preference
19 stuff which at least in some states has gotten
20 pretty much out of hand, or some communities.

21 MS. MUNTHALI: Arjun.

22 MEMBER VENKATESH: So I'm not a

1 clinician that ever immunizes kids and so I don't
2 know that part of it, but I guess the question I
3 ask thinking about it from that perspective is
4 when we have a composite that says do all ten,
5 what that conceptually says is that these are all
6 ten equivalently important.

7 And so I understand the concern that
8 it's going to detract attention. And so if you
9 look through the ten measures, the components and
10 the performance rates, the 25th percentile
11 exceeds 80 percent for, I think, seven of these,
12 the vast majority.

13 The ones where it doesn't exceed that
14 number, the lowest is influenza and then to a
15 lesser degree rotavirus and pneumonia. And so
16 what that makes me think is when I see the
17 composite scores that are quite low that
18 basically, probably means that flu immunization
19 is what is driving the composite to be low.

20 And so the question I would ask you
21 all to think about, and I would like to hear what
22 people who actually do this clinically say is, is

1 would getting a low score, seeing a 38 percent,
2 40 percent in this measure impede the credibility
3 of this measure when you know that your
4 performance is high for everything except flu and
5 what are the implications of that?

6 And the second, I guess, question for
7 the developer that's related to this is have you
8 done analyses that compare in developing the
9 composite that look at the relationships between
10 performances -- I'm sure you have -- performances
11 on several combinations with other combinations,
12 one measure with the other?

13 And so is composite performance
14 variation largely explained just by flu
15 vaccination or is it actually a different world
16 where different plans are underperforming at
17 truly at different measures and the composite is
18 driven by differences in performance?

19 MEMBER HILL: I can tell you from
20 talking with hundreds of physicians that they
21 have a real conceptual problem with this measure
22 because it's a composite measure and they do not

1 measure their performance using this.

2 And so it fails to engage the
3 frontline providers when you're trying to drive
4 quality improvement for these very reasons that
5 have been mentioned. This is mainly in Texas and
6 Florida.

7 MS. MUNTHALI: Matt.

8 MEMBER STIEFEL: I just wanted to
9 follow up on Steve's comment and ask the
10 developers if, and maybe it's in here but I
11 didn't see it. Do we have the percentage of
12 people who opt out?

13 The reason is that potentially becomes
14 a different measure, actually a health
15 population, health and well-being measure about
16 public health efforts to educate people about the
17 importance of this immunization.

18 MS. BYRON: So I've heard a couple
19 different things that sound -- but see if I can
20 get most of them. So just to be clear, NCQA
21 actually reports this measure out for each
22 individual vaccine rate, and then we also have

1 different combinations.

2 And it's actually not just combo 10,
3 we have combinations of all the different
4 vaccines as you go and we report them all out
5 nationally.

6 So, you know, if a health plan wanted
7 to benchmark against combo 5 which is, you know,
8 the first five, then they could do that. I think
9 the value in a composite that I'm hearing from
10 everyone is that you can use it in different ways
11 depending on the program.

12 And in fact we do use the combinations
13 in different ways according to the program. For
14 the longest time combination 2 was the one that
15 was in our health plan accreditation program, but
16 then we realized that we needed to raise the bar
17 and go beyond that. And so then we did push for
18 combination 10 to be used at the health plan
19 level.

20 In order to understand which
21 combinations to use, we did do some analyses on
22 how they hang together so that is a good point.

1 You need to understand which combinations are
2 going to be the most useful.

3 But in order to allow the flexibility
4 and the comparisons for health plans we do report
5 out each individual vaccine rate and then we do
6 report out the combination.

7 So if a health plan wanted to say what
8 is pushing our rate really low, you could look
9 and you could look across health plans to see how
10 others are doing on rotavirus, you know, which
11 does tend to be one that is a little lower than
12 something like flu.

13 So the measure allows for that
14 flexibility. It's really about whoever's
15 implementing the program to figure out which
16 combination that they think is best to be using
17 for accountability or quality improvement or what
18 have you.

19 So this is a health plan measure and
20 across HEDIS we actually do not allow a health
21 plan to say, well, someone refused and so I get
22 an out on the measure.

1 You know, for this measure and many
2 others in HEDIS we feel that it is really the
3 responsibility of the health plan to get this
4 done, and so if someone refused you don't get an
5 exception to it. And we felt that at the health
6 plan level that was appropriate.

7 We do report out regionally as well so
8 that you can look, you know, for those regions
9 where you are seeing a lot of refusals crop up
10 you can look geographically to see how things
11 might be impacted in places like the Pacific
12 Northwest. So, you know, because we do hear
13 about those pockets.

14 But, you know, we report out the
15 measure with the hopes that people will continue
16 to encourage everybody to be getting their
17 vaccinations. So that's the refusal and there
18 may be others.

19 CHAIR McINERNEY: I argue strongly to
20 use the combination of all ten vaccines, because
21 in this day and age of vaccine hesitancy and
22 refusal if we start to say to plans and it then

1 will filter down to physicians, well, this wasn't
2 so important, we're going to have real problems.

3 Because we know already that if we
4 drop below 90 percent, and this has happened
5 several times over the past few years, the most
6 recent and famous of which was the measles in
7 Walt Disney -- the one in California whichever
8 one that is, and -- Disneyland, I guess -- and,
9 you know, and we have problems with infants
10 getting pertussis, infants who cannot be
11 immunized before age 6 months getting pertussis
12 from older children and adolescents who are
13 inadequately immunized and so forth.

14 And so I think it's very important
15 that the plans be, continue to be incentivize to
16 measure all ten vaccine rates.

17 MS. MUNTHALI: Steve, did you have a
18 comment?

19 MEMBER TEUTSCH: I was just going to
20 make the point that not all these vaccines are
21 equally effective either, and the strength of
22 evidence for some of them such as flu in younger

1 kids is not all that great.

2 And I'm sure that leads to some of the
3 differences, so actually I felt better after you
4 said that you can look at these in different
5 ways.

6 But it is a problem when you sort of
7 think of them all the same, because there are so
8 many of these critical ones as Tom was saying
9 where you've got to get them up to high rates of
10 immunization if you're going to get herd
11 immunity.

12 CHAIR McINERNEY: Steve, that's a point
13 well taken. And as probably most of you know,
14 recently the ACIP and the AAP agrees with them,
15 is that intranasal influenza vaccine is not
16 effective and should not be used.

17 I think this is something we need to
18 keep in mind for our flu vaccine measures that
19 are coming up. I'm not sure whether an
20 intranasal flu vaccine is considered appropriate.
21 It should not be from now on. The only vaccine
22 that should be considered appropriate should be

1 the injectable.

2 MS. MUNTHALI: Arjun.

3 MEMBER VENKATESH: So I am totally
4 sold on the conceptual framework that if we
5 promote a full 10 combination that if you get one
6 vaccination you're more likely to get another
7 vaccination would be a reason enough to support
8 the composite.

9 My fear is this, and I think if the
10 developer could share just the correlation
11 between each individual measure in the composite
12 that would be reassuring enough. Because if the
13 correlation between just the flu vaccine and the
14 composite is exceedingly high, north of .8, let's
15 say, then it tells me the composite's really not
16 measuring anything new or different, it's just
17 measuring your flu vaccine rate.

18 Then you have to make a decision,
19 which is this kind of policy or sort of a more
20 quality decision is do you think that encouraging
21 flu vaccination encourages the other vaccines, or
22 do you think that encouraging flu vaccination may

1 create an ala carte mentality?

2 Oh well, okay, there's so many of
3 these different shots let's do the flu shot and
4 maybe not another one that has more evidence base
5 to it.

6 And so I don't know that world of how
7 people react well, but I do think it's if, I
8 think you've got to, you have to know if the
9 composite's actually measuring something
10 different than flu rates or just flu rates.

11 MEMBER HILL: I think that observation
12 on flu is important because basically you're
13 starting every year with a hundred percent gap on
14 flu. So it's a very different type of
15 immunization than the others, right.

16 MS. MUNTHALI: NCQA, perhaps you'd
17 like to address Arjun's point about the
18 feasibility of having individual rates for the
19 individual composites.

20 DR. BARTON: I guess I would say we
21 don't have that data at our fingertips at this
22 moment. I would be glad to go back and try to,

1 and run that but I'm not sure actually that a
2 correlation across all plans who report means
3 that there's not a part of the health care system
4 that doesn't have a different experience.

5 I'm a little bit struggling with your
6 logical model here. I can appreciate that in
7 general if there was very high correlation or
8 even a hundred percent correlation between
9 influenza and the composite, or the 200 health
10 plans or 600 health plans or however, you know,
11 many, many health plans that NCQA assesses that
12 that would be suggestive of a trend or a
13 predominance.

14 But it's hard to imagine that it would
15 actually come back as a one to one, and even if
16 it did does that mean that there's not any part
17 of the health care system that doesn't benefit
18 from having an NQF endorsed composite measure to
19 drive quality and accountability in that sector
20 of the health care system?

21 MEMBER VENKATESH: I guess I would
22 just say that if the correlation, if there is one

1 like you would suppose, then they're not
2 measuring different things they're measuring the
3 same thing.

4 And so we need to have some degree of
5 transparency about that and just, you know,
6 people should be aware that okay, my composite 10
7 score is 30 percent but that's because my flu
8 rate is 30 percent.

9 And so I guess partially that's
10 addressed by the fact that you report out
11 individual measures and people get all that
12 individual information.

13 The flip side is on the use side. If
14 you found people using the composite 10 and not
15 using sub-combinations for use applications, then
16 you could imagine a world where based on whatever
17 the use of the measure is -- accreditation,
18 certification, payment, whatever it is -- if they
19 only used a composite 10 they may be thinking
20 they're actually getting a full 10 composite, but
21 really they're getting the same information as
22 they get from just the flu measure.

1 And so that's, part of this is the
2 intersection between the use of the measure and
3 how this is kind of, you know, currently
4 presented.

5 DR. BARTON: And we can only speak to
6 how we use the measure and by offering measures
7 to be NQF endorsed and thereby offering them on
8 the Quality Positioning System. They're
9 available to people, but it is I would say
10 impossible for us to police every use in every
11 locus of a measure that we've developed.

12 MS. MUNTHALI: I just wanted to piggy
13 back on what Mary was saying. We should be
14 looking at the construct of the measure and the
15 scientific merits of the measure.

16 While our process we say is use
17 agnostic, we do understand that issues -- you
18 live in the world. We all live in the world and
19 so you will consider, you know, the unintended
20 consequences, but we'd like you to focus on the
21 composite right now on 1c looking at all of the
22 issue you brought up.

1 Some of them will be also addressed in
2 2d when we talk about the rationale for our
3 hanging these composites, these components
4 together. But just, Mary, that was a good
5 reminder for everyone.

6 MEMBER HILL: So does this decision
7 that we're making assume or include, the intent
8 is that it includes, there's evidence that
9 supports the logical clustering of these is what
10 we're saying, right?

11 MS. JOHNSON: Yes. It's kind of
12 tricky the way we have composite measures in our
13 criteria because we're actually splitting it up
14 into two pieces. The first piece under 1c is
15 just the rationale for doing it.

16 So in other words, why did you put
17 these ten together? Why wasn't it 11, why wasn't
18 it 9? That kind of thing, right. And Arjun,
19 you're very correct. This is an all or none
20 measure, so the waiting is equal.

21 So we just want to make sure that you
22 guys understand NCQA's rationale for why they did

1 what they did and that's what you're thinking
2 about in 1c.

3 When we get to 2d we're going to go a
4 little further and we're going to hit Arjun's
5 other question which is, is the composite, the
6 10, being driven by perhaps one or two?

7 The question there is if it's being
8 driven by one or two is there a reason to have
9 the composite, why not just have the one or two?
10 That's the question that you'll be looking at
11 under 2d and you'll be looking at the actual data
12 that the developers provided.

13 I don't think, when we get there I
14 don't think you've done those correlations
15 statistics. They would be a little bit of
16 interest, but you've given the individual
17 performance rates for the different components
18 and you can infer from that what's going on.

19 So did that clear up anything or did
20 that add additional confusion to the committee?

21 So it might be useful just to have
22 Mary or -- I'm sorry. Sepheen, just say one more

1 time, you chose to do an all or none with these
2 ten. Just the elevator speech, why did you do
3 that?

4 MS. BYRON: Well, and I do want to
5 emphasize that we have all of them individually
6 and that we report them out nationally by health
7 plan and then we actually do all the different
8 combinations, not just the ten.

9 On the form we submit a combination 10
10 because it, you know, I think when it comes to
11 vaccines there is a thinking that these are the
12 vaccines you should be getting by the age of 2,
13 each is important for different reasons.

14 We have seen rates for different ones
15 decrease in different times, you know, as Tom
16 pointed out MMR one year, pertussis another, and
17 so we do feel that it's important for all of the
18 rates to be, or all of the different vaccines to
19 be reported out.

20 And then the combination 10 we feel is
21 a helpful way to look to see at health plan level
22 is everyone getting their needed vaccines by age

1 2. But if you wanted to you could look at combo
2 5 or 6 or 7 or et cetera.

3 MS. MUNTHALI: Katie.

4 MEMBER SELLERS: I just had a question
5 for the staff here. I was a little confused by
6 where it said the rating is insufficient and it
7 says change here. Is there some significance to
8 that?

9 DR. NISHIMI: No, the change here was
10 notes from something else. I noticed that too.
11 It just didn't get cleaned up.

12 MEMBER SELLERS: Okay.

13 MS. MUNTHALI: Any other questions,
14 concerns, questions for NCQA or NQF?

15 Okay. I think Marcel left, so Ann is
16 12. Okay. We still have four.

17 So this is 1c for a composite and it's
18 a composite explicitly articulated and logical,
19 the quality construct including components, 1c2
20 rationale for distinction additive value, 1c3
21 aggregation and weighting.

22 So your options are 1 high, 2

1 moderate, 3 low and 4 insufficient. And voting
2 is open.

3 (Voting.)

4 MS. MUNTHALI: So for measure 0038:
5 Childhood Immunization Status by NCQA, three
6 voted high, four voted moderate, four voted low
7 and one voted insufficient. So this takes us
8 into the grey zone.

9 This means that consensus was not
10 reached but we continue with voting and we'll
11 resolve this. It's a major criterion and we'll
12 resolve it on the post-comment call. So let's
13 move on to the liability.

14 Katie and Tom, would you like to lead
15 discussion on testing?

16 CHAIR MCINERNEY: Katie, go ahead.
17 Thank you.

18 MEMBER SELLERS: Okay. Okay, for
19 reliability -- sorry, just catching myself up
20 here. Okay.

21 So the questions are, are all the data
22 elements clearly defined and are all appropriate

1 codes included? It seems to me a very clear
2 definition for this combination.

3 And then the next question is, is it
4 likely this measure can be consistently
5 implemented? I think we've seen that it has
6 been. On the testing they use the beta-binomial
7 method to assess signal to noise.

8 A reliability score of 1 would be
9 perfect, zero would be completely random. The
10 score on this from the 2012 committee was
11 reliability statistics ranging from 0.84 to 0.98
12 depending on the vaccine.

13 So it sounds to me like that's not
14 actually the composite measure that we're looking
15 at. Is that correct, these data?

16 DR. BARTON: I'm sorry. You mentioned
17 2012 so I'm trying to find what you're quoting
18 because we quote the 2014 data set. Data, is
19 that what --

20 DR. NISHIMI: Yes, we pulled the
21 reliability from the previous submission. But
22 the --

1 MEMBER SELLERS: Here's the 2014,
2 sorry. 2014 reliability statistics for all ten
3 vaccines was 0.98 for commercial plans and 0.96
4 for Medicaid. So that's quite high. And when
5 you use the reliability algorithm that also
6 brings you to a rating of high.

7 So then the questions for the
8 committee are do the results demonstrate
9 sufficient reliability so that differences in
10 performance can be identified?

11 The previous committee concluded
12 reliability was high with reliability statistics
13 of 0.84 to .98. The updated testing reveals
14 reliability statistics of 0.89 to 0.98. Does the
15 committee agree there's no need for repeat
16 discussion and voting on reliability?

17 MS. MUNTHALI: We're seeing nods, yes.
18 So we'll move on to validity.

19 MEMBER SELLERS: Okay. So the first
20 question is are the measure specifications
21 consistent with the evidence, and the
22 recommendation here is yes.

1 If we look at the validity testing,
2 let's see. So the last time this was reviewed in
3 2012, they provided face validity testing. This
4 time it's still face validity only but the
5 developer submitted a t-test and it's a little
6 bit unclear how the t-test relates to validity.

7 So I would like to ask the developers
8 to clarify that relationship there.

9 MS. BYRON: Yes, sorry. That was our
10 error. We meant to put that under the test of
11 meaningful differences section which is 2b5. So
12 sorry about that confusion.

13 MEMBER SELLERS: Okay. So I think
14 what we're looking at here is the same validity
15 information that was provided in 2012 which is
16 face validity only.

17 MS. MUNTHALI: And again, the
18 committee can opt to just accept their previous
19 decision from 2012. Is that a yes? Nodding,
20 yes. So we'll move on to 2d.

21 MEMBER SELLERS: 2d?

22 DR. NISHIMI: Yes. There was an error

1 in the construction of the PA, so Karen is going
2 to have to walk through. It really goes to
3 Arjun's question about what's driving the lower
4 rates in the all 10 and whether that undermines
5 the construction or whether it's fine.

6 Karen, can you walk through the
7 composite issue?

8 MS. JOHNSON: Sure. So it might help
9 if we could pull up the 2d criterion so you can
10 see how you're voting on 2d on your voting
11 slides. Yes. This is our mistake and apologies
12 for this. We forgot subcriterion 2d on your PA,
13 so sorry about that.

14 But again just to describe what 2d is
15 about, the question is -- you can see it on your
16 screen on the voting screen. Four composite
17 measures we want to know is there empirical
18 analyses to support the composite construction
19 and demonstrate that the measures fit the quality
20 construct, add value, parsimony to the extent
21 possible, aggregation and weighting fit the
22 quality construct and simplicity to the extent

1 possible.

2 These things get really complicated
3 when you have really complicated composite
4 measures. In reality, this is a pretty simple
5 all-or-none composite measure, right.

6 So basically the quality construct is
7 that they've decided that these ten components go
8 into the one composite, and we just want to know
9 is there any empirical analysis that really
10 supports that?

11 So in other words that the composite
12 itself is telling you something different than
13 what you would know from the individual measures,
14 okay. Again it really is Arjun's question all
15 over again.

16 Now they -- I don't think, and this is
17 something that is also a little bit confusing
18 because this measure is older than our most
19 recent composite guidance, okay. We did this
20 composite guidance, I think, in 2013, so quite a
21 bit after you guys had done this before.

22 And in our effort to try to make the

1 submission process a little less onerous for
2 developers we did not insist that they update to
3 our newest forms, which means that they also
4 didn't fill out 2d for you, okay.

5 But what they have is data that a lot
6 of people do provide for all-or-none composites.
7 Often for an all-or-none composite, if they're
8 using our current form for 2d they will just show
9 you the rates for the individual components. You
10 have that under 1b, under gap, right, because
11 they told you what the performance rates were for
12 all of those individual components.

13 So you can look at that and I think
14 really the question is, is all of those necessary
15 to the composite, is anything kind of extraneous
16 to the composite, is one of two things pretty
17 much driving the composite?

18 You may be able to tell that from the
19 performance data that were provided under 1b. It
20 would be interesting to know if NCQA might be
21 able to do that correlation analysis that Arjun's
22 requested. That might tell you something a

1 little bit different than the performance rate.

2 You can decide if you need to see that
3 before you could rate or not. But I shouldn't
4 just assume that NCQA would be able to do that
5 analysis either. So that would, I think, be a
6 question for you guys.

7 MS. JOHNSON: Within, I think within
8 probably a two-month period, something like that.

9 DR. BARTON: We'd be glad to do those
10 analyses, and as you know we're glad to fill out
11 the forms that you ask us to fill out. And so we
12 could have done it in advance if we'd known that
13 this was going to be part of it. Although in all
14 honesty, as Sopheen has pointed out -- I'm sorry
15 -- we have a number of ways that we present this
16 data.

17 Back to plans, each individual rate,
18 a number of composites. We could withdraw
19 composite 10 from being considered and just have
20 the individual rates in our proposed measure,
21 then it's not in NQF's Quality Positioning
22 System.

1 I see Tom shaking his head, but I
2 would say that it was not our suggestion that
3 this be considered as a composite. It was NQF's
4 suggestion.

5 MS. JOHNSON: And just to make sure
6 everybody understands, we did an expert group
7 come-together a few years ago and they all agreed
8 these all or none measures, which are kind of a
9 different animal than the individual measures, we
10 also want to think about them as composite
11 measures.

12 And it is a fair question, you know,
13 are the things in there useful. I think in terms
14 of, you know, pulling composite out of here that
15 would certainly be an option, but if you feel
16 strongly that that composite, that 10-point
17 composite is really offering something, you know,
18 then you probably wouldn't want to do that.

19 And I would also say, you know, that
20 extra data may not be needed by the committee.
21 They may be able to look at your performance
22 rates and not even ask you to do anything.

1 So, Arjun.

2 MEMBER VENKATESH: Karen, is it
3 possible, do they have, do you all have face
4 validity testing for the all-10 composite?
5 Because if you have that could we use that to
6 say, A) that's good enough to say that the
7 composite's valid, because people say you should
8 measure all 10 together as an all or none, and
9 then ask that they bring data later. Is that an
10 option?

11 MS. JOHNSON: It could be a
12 compromise. I think I would prefer that you look
13 at those performance rates and just make sure
14 that you feel like something from those
15 performance rates are helping.

16 We actually see 2d as something a
17 little different than just validity testing.
18 It's sort of validity but it's something separate
19 so it's its own subcriterion. That would
20 certainly bolster, you know, I could see some
21 people saying that would bolster their comfort.

22 MS. MUNTHALI: Steve.

1 MEMBER TEUTSCH: Yes. Along the same
2 lines, because so for full disclosure I was on
3 the U.S. Preventive Services Task Force for a
4 long time and obviously we have a lot of problems
5 with being incomplete on lots of different
6 preventive services.

7 But for the interest of parsimony as
8 we get to some broader measures that can be used
9 at a population level, having things like up to
10 date on your clinical preventive services so it
11 differs in exactly what those are, what based on
12 your age and your gender and other things, but
13 having that as a measure of how well you're doing
14 is, you know, at some level those are more
15 informative at population levels than all the
16 detail that you get mucked in if you've got to go
17 and deal with this in a real world in a plan or
18 something where you want to see exactly where
19 your deficits are. It's a different animal.

20 And so I would say that in general
21 moving towards some of these larger scale,
22 broader composite measures offer a lot at a

1 population level.

2 I know this is sort of in the clinical
3 stuff, but if you're really trying to deal with
4 stuff at a population level this is great,
5 because then you've got to drill down and you
6 start answering the questions that Arjun's
7 asking.

8 All right, which one is it that I've
9 got a problem with? Who, which are the people?
10 Which is the geographic areas? So I find these
11 things actually pretty helpful to deal with
12 things that are at a more population oriented
13 level because it's a place to start.

14 If I'm doing great on this measure,
15 good. Then I'm going to go onto something else
16 where I've got a problem. And if I've got to
17 keep getting buried down in all the detail all
18 the time, it really bogs down a lot of the
19 processes and makes some of the communications on
20 priorities and other things more challenging.

21 MS. MUNTHALI: Patricia.

22 MEMBER McKANE: Yes. I think my point

1 is almost the same and I hope it's a little bit
2 different, but as an epidemiologist when I see
3 composite I just kind of, I cringe because I
4 think, you know, it's as Arjun said the weighting
5 and some are more important than the others.

6 But I really do see a value with this
7 as Steve said, you know, to measure you're
8 measuring health plans. This isn't measuring the
9 population, but yet it's kind of giving us an
10 indicator or a signal of what's going on in the
11 population.

12 And I think that we might just have to
13 be clear and it behooves us to know it's a
14 composite. That there are other factors that are
15 going into it and that we do need, as you said
16 you report out on all of it, you know, and give
17 that information. Because there is value in the
18 individual, but also looking at it as a group.

19 And I think just from my point of view
20 is making sure, and I'm not the expert here so
21 I'm really trusting that these immunizations,
22 these ten vaccines are the ones that are critical

1 and they are all important to be completed by age
2 2.

3 MS. MUNTHALI: Marcel.

4 MEMBER SALIVE: Yes. So just, I
5 guess, one small piece to add on is that I think
6 we've discussed this in the past, I think, at
7 this committee about harmonizing with the
8 population measures.

9 And so I think there is some link here
10 to Healthy People 2020, where it's not exactly
11 the same but it's got some composites in there
12 which I think are useful and it does also look at
13 the individual ones.

14 So, but, you know, to Steve's point I
15 think, you know, the plans contribute to that.
16 Everyone contributes to that and so we have to,
17 you know, having that harmony a little bit or
18 some way of looking at it is helpful for all the
19 local efforts.

20 MS. MUNTHALI: Arjun.

21 MEMBER VENKATESH: I'm trying to
22 figure out some way to help you guys through this

1 and like where we can like, because I think the
2 challenge you're all having is that we've got ten
3 individual measures but there's a bunch of
4 combinations, right.

5 So we're doing like one vote for some
6 exceedingly number high of combination of
7 measures. And so what I'm stuck with, I guess,
8 is that the question we have in front of us is
9 about what's the incremental values, their unique
10 value of a composite versus the individual or
11 versus the other measures?

12 I'm looking at two composites, what
13 you guys call combination 7 and combination 10.
14 The only difference in those two measures is flu.

15 And so I'm trying to figure out how
16 to, what I think is conceptually makes a ton of
17 sense to do an all-or-none, what conceptually
18 makes a ton of sense is it seems to be consistent
19 with a variety of other recommendations.

20 I don't know the guidelines and the
21 various possible recommendations as well, but to
22 me it's just then the combination 7 versus

1 combination 10. The only difference in those two
2 composites is flu or no flu.

3 And so either you could say, hey,
4 conceptually we pick and say endorse 10, which is
5 the one that's in front of us, because it sort of
6 makes sense and there's some face validity to
7 having it together, or if you really hold us to
8 the question of is there data to suggest that
9 combination 10 is parsimonious and provides
10 incremental value of a composite, I can't answer
11 that question with any high certainty.

12 So I'd probably be left with a low to
13 moderate, but as far a combination 7 then, just
14 guessing basing it individual measure scores I'm
15 more likely to be in a spot where the composites
16 tell me more than I get from individual.

17 DR. NISHIMI: Arjun, I just need to
18 clarify something for you and the committee.
19 NCQA's previous submission included all those
20 other combinations.

21 They clarified that for this
22 maintenance mission they're only seeking, if you

1 look at the first page not all the other data,
2 they are now only seeking endorsement of the ten
3 individuals and the one all-10 now.

4 That's all that this particular, the
5 reason you see the other data is because it's the
6 old form. But this committee's deliberations are
7 now focused just on the individual ten and the
8 all-10.

9 MEMBER HILL: And if I can just add on
10 to where you're coming from, Arjun, I've sat in
11 on the health plan negotiations where the NCQA-
12 endorsed measures be turned into insignificant
13 influences on your fee schedule and how things
14 are going, you know, at the patient level.

15 And so if we endorse 10, what I
16 suspect is the next negotiation I sit in on, 10
17 will be the only thing on the table, not 7, not
18 5, not 1, no matter where you are.

19 And so that's going to affect a one to
20 three-year contract. I mean, this is some of the
21 practical things that happen when we endorse a
22 composite measure.

1 MS. MUNTHALI: Other questions,
2 comments or concerns? Okay.

3 OPERATOR: If you would like to make
4 a comment, please press star 1.

5 MS. MUNTHALI: Only for the committee.
6 We're not at a public comment yet.

7 Okay, so we'll be voting for measure
8 0038. This is the Childhood Immunization Measure
9 by NCQA, 2d. This is, you know, making sure
10 there's an empirical analysis that's supported by
11 the composite construct and it's demonstrated

12 And the options are 1 high, 2
13 moderate, 3 low and 4 insufficient, and voting is
14 open.

15 (Voting.)

16 MS. MUNTHALI: All right, for measure
17 0038, three voted high, seven voted moderate,
18 three voted no and zero voted insufficient. So
19 this passes, 2d, and so we'll go on to
20 feasibility.

21 Katie and Tom.

22 CHAIR McINERNEY: Katie, you mind going

1 again? Thanks very much. You're doing a great
2 job.

3 MEMBER SELLERS: Sure. Thank you. So
4 we're moving on to feasibility. This is already
5 in use, widely used. There are no issues
6 identified regarding feasibility.

7 MS. MUNTHALI: Comments from the rest
8 of the committee?

9 MEMBER HARRIS: I just wonder why it
10 was coded as moderate versus high.

11 DR. NISHIMI: For the same reason as
12 the last one because it says some data.

13 MEMBER HARRIS: Okay.

14 DR. NISHIMI: It's a judgment call.
15 The committee can choose to go high.

16 MS. MUNTHALI: Okay. It looks like
17 we're ready for a vote. So for feasibility,
18 measure 0038, 1 high, 2 moderate, 3 low, 4
19 insufficient. Voting is open.

20 (Voting.)

21 MS. MUNTHALI: Okay. So four voted
22 high, nine voted moderate. So for 0038 the

1 committee has passed on feasibility, so we move
2 on to usability and use.

3 MEMBER SELLERS: For usability and use
4 it is reported that this is currently used,
5 currently publicly reported, used in an
6 accountability program. Well, they list six
7 accountability programs including NCQA health
8 plan rating.

9 For improvement results they do note
10 that during the last five years performance has
11 improved across commercial plans. The proportion
12 of children documented as having received all ten
13 vaccines moved from less than a fourth to about
14 half. For Medicaid plans it went from about 15
15 percent to a little over a third. The 2014 rates
16 are still showing room for improvement, 47.6
17 percent for commercial plans, 36.1 percent for
18 Medicaid plans.

19 They note that receipt of some
20 individual vaccines is high, while others remain
21 low. Large differences between the lower and
22 higher performing plans exist. The range among

1 commercial plans -- sorry.

2 The average rate among commercial
3 plans was 28.4 percent in the 10th percentile,
4 and up to 63.2 percent among those in the 90th
5 percentile. For Medicaid that range was 23.4
6 percent to 49.6 percent.

7 The developer's not found any
8 unintended consequences during testing or since
9 implementation. They don't report any potential
10 harms.

11 They do note that -- the 2012
12 committee noted that in times of vaccine
13 shortages, adjustments or explanation may need to
14 be made for the rates.

15 And the question for the committee is:
16 can the performance results for this measure be
17 used to further the goal of high quality
18 efficient health care? And the staff preliminary
19 rating for usability and use was high.

20 Questions or comments?

21 MS. MUNTALI: It looks like we're
22 ready for a vote. So one, high; two, moderate;

1 three, low; four, insufficient information.

2 Voting is open.

3 (Voting.)

4 MS. OGUNGBEMI: Michael, if you could
5 submit your vote via the chat, please.

6 MEMBER BAER: It should be there now.

7 MS. OGUNGBEMI: Received.

8 MS. MUNTHALI: So, we have 13. Yes,
9 13. So 12 voted high; 1 voted moderate.

10 So as you remember, we did not reach
11 consensus on 1(c). It's a major criterion, so we
12 cannot proceed to an overall vote. We will
13 resolve that issue during the post-comment call,
14 and we'll further discussion of that criterion,
15 re-vote on 1(c), and then do an overall vote.

16 So that post-comment call is in about
17 two months or so, two and a half months.
18 December 6th, okay. So thank you. So we are --
19 oops, Matt.

20 CHAIR McINERNEY: Just one quick
21 question for NCQA. Have you at all correlated
22 your results with the state registries? Do you

1 find them helpful? Do you think there would be
2 any value in doing that?

3 MS. BYRON: That's a good question.
4 And for this particular measure, actually, I'm
5 not sure we have, but recently for the HPV
6 vaccine measure because that is one that we had
7 been updating the most recently, we did look at
8 state registries.

9 And we did find that the results in
10 the field testing among health plans compared to
11 the registries were similar, so you did see the
12 same vaccines being higher in one and higher in
13 another and, you know, vice versa.

14 The state registries vary widely
15 across the U.S., you know, some are very good;
16 some are not and we are hoping to get to a point
17 where the registries are all giving really good
18 information.

19 I think the primary issue is how you
20 handle certain things like accounting for the
21 denominator. So a lot of state registries have
22 people in them, but when they move out of the

1 state they may not be removed.

2 So dealing with issues like that I
3 think we still have to allow the registries to
4 catch up, but we do allow plans to use registry
5 data to report the measure, and they're all
6 audited, so --

7 MEMBER STIEFEL: Just a question for
8 NCQA for future consideration, and that's whether
9 you've considered a weighted average composite,
10 which would maintain the value of parsimony but
11 increase the validity of the measure because of
12 the -- and weighting may be based on impact on
13 population mortality and morbidity.

14 MS. BYRON: Thanks for the suggestion.
15 You know it's interesting because with the
16 vaccines, you know, and the combinations, we've
17 looked at other measures and composites such as
18 for well care with children, you know, looking at
19 BMI and then counseling and then risk assessment.

20 And definitely it's more complex in
21 thinking about whether everything should be
22 weighted the same or whether it should be all or

1 nothing or should it be around, you know,
2 opportunity to provide the service.

3 For vaccines, I think we felt it was
4 a little bit more straightforward, but I think we
5 can look into that.

6 DR. BARTON: And you know, we've
7 certainly been interested in the panel's
8 feedback. I guess what's hard to understand is
9 that the ACIP is seen, coming from the CDC, to be
10 the foremost authority on what age-appropriate
11 vaccinations are.

12 And so as we are consumers of
13 guidelines and recommendations from august bodies
14 such as ACIP and USPSTF, it's in -- while there
15 are potentially interesting scientific byways to
16 go down, it seems like the further we get away
17 from those authoritative bodies the harder it
18 will be to come before the next NQF panel.

19 MEMBER TEUTSCH: So I worry actually
20 about ACIP, just like I do with groups that are
21 constituted by other professional organizations
22 that actually are very committed to whatever the

1 technologies are.

2 I don't think it differs all that
3 much. These are people who are very committed to
4 vaccines as the solution. And there are a lot of
5 people who are there who are heavily invested.

6 And so I don't think it differs
7 radically from what you see from other
8 professional groups that have similar kind of
9 vested interest. They tend to be pretty
10 aggressive about approving things in my
11 estimation.

12 I know they are the authoritative
13 body. I can't tell you where else to go. But I
14 would think that if you actually had a body that
15 was constituted somewhat differently, that didn't
16 have as its mission basically just the control of
17 diseases, but looked at all the data in a
18 different type of critical way, you would end up
19 with different recommendations.

20 As we're going to talk about in flu,
21 some of the data are not all that strong in some
22 of these age groups. So there is a willingness

1 to extrapolate, and to groups that -- others who
2 are looking at a different level of critical,
3 they might come up with different things.

4 The Brits have different, who are very
5 evidence-oriented, have different
6 recommendations, for example.

7 So I don't think, I don't have any
8 wisdom to shed on what you should do other than
9 use them, but I do think we have to realize where
10 all these recommendations do come from that we,
11 you know, we ensconce sort of in these metrics.

12 MS. MUNTHALI: Thank you. So we will
13 move on to the next measure which is 0039. This
14 is the flu vaccines for adults ages 18 and older.
15 This is also stewarded and developed by NCQA.

16 Before we begin, there are a couple of
17 things we need to take care of. First, Michael
18 Baer is on the line. He's our committee member.
19 He missed our intro and disclose of interest. So
20 Michael, I'll ask you to introduce yourself and
21 let us know if there's anything you'd like to
22 disclose in relation to this.

1 MEMBER BAER: Sure, thank you. I'm
2 from AmeriHealth Caritas Pennsylvania. It is a
3 Medicaid managed care company in Pennsylvania,
4 and I have no disclosures.

5 MS. MUNTHALI: Thank you very much.
6 And on the heels of Steve's last comment, we did
7 have a suggestion to make the next round of
8 influenza vaccine measures more efficient.

9 Staff has determined that the evidence
10 base for all of them, they're based on the ACIP
11 guidelines, and we pretty much have given it the
12 same evidence rating across all of the measures.

13 I think there are eight influenza
14 measures. And what we would like to recommend,
15 if you'd like to take it up, is that we could
16 vote. You could either decide to vote on
17 evidence for all of them knowing that same basis
18 for evidence, or you can decide to forego
19 conversation on evidence for all.

20 Well, there are seven maintenance
21 measures, one e-Measure, but it is the evidence
22 basis is based on a current maintenance measure,

1 claims based measure, or we can have discussion
2 on evidence for 0039, and that vote can carry
3 over to the remaining influenza vaccine measures.

4 So we can either forego that for those
5 of you who've reviewed the evidence for the
6 influenza vaccine measures, if you'd like to
7 comment on that. So Marcel.

8 MEMBER SALIVE: Well, I'd like to have
9 a small discussion on evidence. You know, I
10 don't think I want to discuss each one
11 individually.

12 MS. MUNTHALI: Okay. So let's start
13 off with the measure before us. So Mary and
14 Jenna.

15 MS. WILLIAMS-BADER: Hi, my name is
16 Jenna Williams-Bader, and today I'll be talking
17 about our flu vaccinations for adults 18 and
18 older.

19 So this measure assesses the
20 percentage of adults 18 years of age and older
21 who self-report receiving an influenza vaccine
22 since July 1st through when CAHPS is

1 administered, because this is collected using a
2 CAHPS question.

3 There are two age stratifications, 18
4 to 64, and 65 and older. It is a health plan
5 level measure like the two you've already
6 discussed, and it's reported for commercial and
7 Medicaid for the 18 to 64 age population, and
8 then Medicare for the 65 and older.

9 This is a very longstanding measure,
10 and at NCQA we do still see room for improvement
11 with Medicaid performance about 40 percent,
12 commercial about 49 percent, and Medicare about
13 73 percent.

14 And this measure is used in a number
15 of programs including NCQA's health plan ranking
16 and our accreditation, the Medicaid Adult Core
17 Set, and Medicare Stars.

18 MS. MUNTHALI: Great, thank you. So
19 I think the lead discussants on this one are
20 Catherine Hill and Michael Baer, so I'm not sure
21 who wants to start off.

22 MEMBER HILL: I'd be happy to. Are we

1 going to skip the evidence on this?

2 MS. MUNTHALI: So Marcel had put a
3 motion out that we at least talk about it a
4 little bit, yes.

5 MEMBER BAER: I just want to say thank
6 you, Catherine. This is Mike Baer.

7 MEMBER HILL: No problem. All right,
8 so on the evidence, we see that it does have a
9 systematic review that the quality, quantity, and
10 consistency of the evidence provided was good.
11 That it does not have a graded evidence.

12 The developer has updated the evidence
13 for this measure, adding the 2015-2016 ACIP
14 recommendations, and the measure of course as
15 you've heard remains aligned with those
16 recommendations.

17 The question for the committee was the
18 developer has reported that this guideline has
19 been updated, but the 2015 update, and that 2015
20 update does not really impact the measure, is
21 deemed consistent with the specifications.

22 And as the committee, we are tasked

1 with trying to decide whether we agree, whether
2 there's no need for repeat discussion and voting
3 on the evidence. And I hear from my colleagues
4 that we do want to discuss the evidence. It's
5 got a preliminary rating of high.

6 MS. MUNTHALI: Michael, anything to
7 add?

8 MEMBER BAER: I have nothing to add,
9 thank you.

10 MS. MUNTHALI: Okay, Marcel.

11 MEMBER SALIVE: So I reviewed it for
12 a different measure, too, but I wanted to just
13 have a short discussion, because I mean, I think
14 it's important just to reflect on this.

15 So the flu vaccine does change every
16 year, or it has the potential to change every
17 year, and so, you know, then the recommendations
18 also have the potential to change every year.

19 And as was mentioned, I think, by the
20 chair earlier, you know, there's now this new
21 recommendation relating to the nasal flu vaccine
22 which, you know, affects this one and some of the

1 other measures I think.

2 So, you know, I view the ACIP as
3 equivalent to the U.S. Preventive Services Task
4 Force which is what, you know, I think Congress
5 said that and very, you know, it's not exactly
6 the same. I kind of agree with Steve in some
7 ways.

8 But it's very strong recommendations
9 generally speaking, but, you know, they're
10 tempered by kind of the real world and what's
11 going on.

12 So, you know, I think we have to just
13 reflect that and say that you know, in general
14 the evidence is very strong, but then, you know,
15 year to year, there might be some issues that
16 affect measures, affect what people do, affect
17 the trends, everything.

18 So, and you know, ongoing research is
19 always ongoing also each flu season. So, and
20 that's how they find those things out. So, you
21 know, I'm fine with that, but it just seems like
22 we should discuss it and, you know, hear how

1 maybe the measure developer deals with it, you
2 know, because it seems like it's a little bit of
3 a moving target.

4 But again I think it's important, but
5 I don't think -- you know, the evidence doesn't
6 seem like it's going to go in the negative
7 direction, but I would never, you know, foresee
8 that I guess myself.

9 So I think, you know, it's always,
10 that's why I wanted to discuss it, really. And I
11 do think it applies generally to all the measures
12 that have flu in it, and so it's worth having a
13 short discussion.

14 MS. MUNTHALI: Mary.

15 DR. BARTON: If I might, this is Mary
16 Barton. I would just like to speak for NQF here,
17 because NQF uses a process that asks us to update
18 specifications or changes to specifications
19 annually, where new guidance, there's a pathway
20 for new guidance to be surfaced in a very timely
21 manner.

22 And so I think while the committee

1 sees the endorsement that is coming at a several-
2 year interval, in fact, the NQF staff are working
3 with measure developers on a much more frequent
4 basis.

5 And so I think, while I can understand
6 your concerns I suspect if you were involved in
7 some of the interim calls, you might feel more
8 confident about how NQF is using the measure
9 maintenance cycle to make sure that when codes
10 change or practice shifts that those things are
11 taken account of.

12 MS. MUNTHALI: And that's part of our
13 annual update process. Thank you, Mary.

14 And if there are no material changes,
15 you're likely not going to see them, but a
16 material change would trigger an ad hoc review,
17 and then we'd bring it in front of the committee.

18 So it is an annual review that's in
19 between the three-year review, so there's an
20 opportunity for developers to update their
21 measures according --

22 MEMBER SALIVE: So I think to me, the

1 nasal flu recommendation is a material change,
2 right, and I appreciate that there is this
3 process.

4 I think I was part of one of the
5 reviews in the past where things were being
6 updated; maybe it was pneumococcal. But, so I
7 appreciate that but I think, you know -- okay,
8 enough said.

9 MS. MUNTHALI: And I think the point
10 you raised about a moving target is something we
11 should think about, because when we put out this
12 call for measures, it was last year in October.

13 So developers are working with us
14 throughout the process. I don't know if they
15 will ever get caught up to whatever is most
16 current, and you know, measure development is
17 very resource intensive in terms of the dollars
18 and staff time, budgeting.

19 So as much as possible we do know that
20 what we're trying to do here, what we were asked
21 to do by the federal government in 2008, is
22 standardize immunization specifications. So we

1 ask that at a minimum, the measures that come
2 through our process, whether they're influenza
3 vaccine measures or pneumococcal vaccine measures
4 that they're at least standardized in that sense.

5 But, you know, it's a point well
6 taken. I don't know how we'll ever get caught up
7 depending on, you know, where we are in our
8 process and where developers are in their update
9 process. They also have updating cycles as well.

10 CHAIR McINERNY: So for this year and
11 future years, will you not count intranasal flu?
12 Do you --

13 DR. BARTON: This is an adult measure.

14 CHAIR McINERNY: Right.

15 DR. BARTON: So there are no children
16 in this measure.

17 CHAIR McINERNY: So, but what does
18 ACIP say about intranasal flu for adults? What?
19 Anybody know?

20 DR. BARTON: I believe it's
21 applicable.

22 MEMBER TEUTSCH: Yes, but along the

1 same line, I'm really interested in how things
2 are done when you get to variations, such as for
3 the over-65 population, there's been an intent to
4 use a higher potency vaccine. And as you know,
5 there are age limits for the intranasal and
6 they're likely to, they may well change it at
7 various times.

8 To what extent does this measure
9 actually capture that level of detail? And maybe
10 even should it? I mean, if you got vaccinated
11 with a regular vaccine and you're over 65, you
12 know, you're getting partial protection, maybe
13 even most of the protection, but you're not doing
14 the optimal. So what do you capture, and how
15 does it vary over time?

16 MS. WILLIAMS-BADER: So this measure
17 as I pointed out, is collected using a CAHPS
18 survey question, so we need to ask the question
19 in a way that people are going to understand.

20 The question right now is have you had
21 either a flu shot or flu spray in the nose since
22 July 1st of the year in which we're measuring.

1 If we were to use claims, we would
2 likely miss quite a few flu shots that were
3 administered because the flu vaccines are being
4 given in a number of different areas outside of
5 the physician's office, and those claims are not
6 necessarily getting to the plan.

7 So as a plan-level measure, we have to
8 make a choice about which data source is likely
9 going to give us the best information, and for
10 this one, we think it's the survey question.

11 MEMBER TEUTSCH: But we were talking
12 about evidence generally, and I'm just curious to
13 what extent we, you know, how precise do we want
14 to be?

15 I mean, in many ways, what you're
16 saying is very practical and makes a lot of
17 sense, but in some sense, it's not optimal. And
18 I'm just curious as, not just for this one but
19 for the whole set of measures, what's being done,
20 and how consistent is it? And is there some
21 harmonization across all of this?

22 MS. MUNTHALI: It's a great question.

1 The committee will have to determine the degree
2 to which we're not prescriptive about, you know,
3 the precision of any of what we require in terms
4 of evidence or the testing.

5 However, because NQF has done
6 significant work, and this committee has done
7 significant work, in trying to make sure that at
8 least we've accepted the ACIP guidelines, and at
9 least for influenza vaccines, that they're
10 harmonized; the measure specifications for the
11 measures that are in front of you are harmonized
12 to the extent possible.

13 Now there may be reasons why they
14 can't be. There are different data sources,
15 different things like that. But that will be up
16 to your discretion to decide.

17 So I know it's not easy. We didn't
18 give you an answer, but these are the sort of
19 things you should be talking about.

20 And just to add, in your preliminary
21 analyses, what we did as staff is to point out
22 where these are standardized with our standard

1 specifications and where they're not and where
2 the misalignment is.

3 Are there any other questions on
4 evidence? Michael, any questions or comments?

5 MEMBER BAER: I have nothing further.
6 Thanks.

7 MS. MUNTHALI: Okay, great. So we
8 will vote on evidence for Measure 0039: Flu
9 Vaccines for Adults ages 18 and older. One is
10 high, two is moderate, three is low, and four is
11 insufficient, and voting is open.

12 (Voting.)

13 MS. MUNTHALI: So 11 for high, 1 for
14 moderate, and 3 -- I'm sorry. It switched over.
15 I guess it was one. 11 high, 1 for moderate, and
16 3 low. So in percentages 85 percent high, 8
17 percent moderate, and 8 percent low.

18 And so we'll go to performance gap.

19 CHAIR McINERNEY: By the way I just
20 looked up the ACIP recommendation, and it says
21 that the ACIP voted that live attenuated
22 influenza vaccine, also known as nasal flu,

1 should not be used during the 2016-2017 seasons.

2 ACIP continues to recommend annual flu
3 vaccine but needed to be inactivated influenza
4 vaccine or recombinant influenza vaccine for
5 everyone 6 months and older. So it sounds to me
6 like that includes adults.

7 But I agree that -- then the next
8 paragraph they go on and talk about the problem
9 with LAIV for children through 17. I don't know,
10 and it doesn't say anything about adults as
11 having a problem, but the recommendation sounds
12 like it should be for all.

13 So we probably ought to try and
14 confirm that with ACIP, because I think it's
15 important. And, you know, then the problem is
16 with it using a CAHPS measure. Yes, you know,
17 people are going to say, yes, I got a flu
18 vaccine. Whether they say it's nasal or shot,
19 you're not going to know.

20 DR. BARTON: Yes. Unfortunately the
21 CAHPS cycle is such that this recent guidance
22 would have been impossible to get into the

1 government approval for changing a CAHPS item.

2 It's somewhat ironic, but I think it's
3 a good impetus to us as we continue to try and
4 update our immunization measures in particular by
5 looking at alternative data sources so that we're
6 not reliant on survey.

7 CHAIR MCINERNEY: Right.

8 MS. MUNTHALI: Great. Catherine.
9 Michael.

10 MEMBER HILL: All right, so now we're
11 going to talk about the performance gap, and here
12 we're looking at the fact that there is data to
13 demonstrate some variation or overall less than
14 optimal performance across providers and
15 populations.

16 What we see submitted is that
17 commercial mean is 49.2. The Medicaid mean is
18 39.8. In terms of disparities, here's another
19 example, just like what Matt said earlier where
20 we would like, the committee would like to see
21 disparities assessed in order to target the
22 populations, at-risk populations.

1 We do have some data that shows that
2 influenza coverage was 31.5 percent among adults
3 age 19 to 49, and 47.7 percent among adults age
4 50 to 67. That there were disparities in
5 coverage observed for most racial and ethnic
6 groups.

7 That our influenza coverage for whites
8 age 19 and older was 47.6, versus that for blacks
9 which was 36.5 percent, and for Hispanics, 33.2
10 percent.

11 The question before the committee was
12 is there a gap in care that warrants a national
13 performance measure, and I'd like to remind you
14 of my point of view, and that is each year, we
15 start with a hundred percent gap. And so it is
16 an annual challenge that we have to drive, and it
17 is really important.

18 This has been a critical measure for
19 the 16 counties that I have practiced in and
20 worked with to reduce hospitalizations and to
21 regionally benchmark especially our rural health
22 efforts where access to care is sometimes

1 challenging.

2 So I think it's really helpful to
3 collect this data by this age category because
4 we've been able to make some improvements in my
5 area of the country by working with our existing
6 infrastructure and processes. So it's rated high
7 as an opportunity for improvement.

8 MS. MUNTHALI: Michael, anything to
9 add?

10 MEMBER BAER: Not a whole lot to add.
11 I mean, I agree with everything that Catherine
12 said, and I'm just not sure how the CAHPS is
13 administered and if it gathers, it doesn't sound
14 like it gathers the ethnic, race, language, and I
15 do feel this is important.

16 I thought there was an interesting
17 comment that was on the preliminary evaluations
18 about anti-vaxxers versus, well, anti-vaxxers
19 maybe skewing or changing the disparities over
20 time because of, you know, folks not wanting
21 their children to get the flu shot.

22 And that predominately is in the

1 educated white population, whereas the less well-
2 to-do families and those in the black and
3 Hispanic populations would not have as high a
4 rate.

5 So it's interesting how there could be
6 an influence on this. I don't know how much of
7 an influence that will be, but I do think that
8 you know, it's one of those sub-groups that could
9 affect disparities.

10 MS. MUNTHALI: Mary or Jenna, did you
11 want to address --

12 DR. BARTON: No. I was just trying to
13 get my head around appreciating lower rates in
14 whites because it equals disparities, because
15 that seems rather counterintuitive to me about,
16 you know, what the health care system is, the
17 responsibility of health care system to give
18 everybody the vaccines that they need, everybody
19 up to date.

20 So in terms of CAHPS, we're just
21 trying to track down now the degree to which
22 CAHPS data may be reported. I'm not sure that

1 race and ethnicity is fully included. Certainly
2 it's not in the data that we get for the measure,
3 which is again at a health plan level.

4 MEMBER BAER: Yes. And I think you've
5 mentioned before that, you know, and I'm with a
6 health plan, so at the health plan level I know
7 that we do look at this.

8 You know, we have a Health Equities
9 Council, and, you know, we certainly are going to
10 be drilling down into our data. Not only do we
11 drill down, but as we are a managed care company
12 in Pennsylvania that has to answer to the
13 administrator of the Medicaid program in
14 Pennsylvania, the administrator of the program in
15 Pennsylvania is keen on, you know, us looking at
16 the disparities.

17 So, you know, while we may not get
18 this at the CAHPS level, I do know that plan-
19 level data is being drilled down into -- you
20 know, in trying to be able to capture the race
21 and ethnicity correctly for those who are in our
22 plan is an issue. So I can see that that could

1 become an issue, you know, if we tried to do this
2 at the CAHPS level.

3 So, you know, I do think that we
4 struggle with trying to capture the correct race
5 and ethnicity, but I do think that if it's not at
6 the CAHPS level that we are looking at it at the
7 plan level.

8 MS. MUNTHALI: Jacki, Matt, then
9 Barry-Lewis.

10 MEMBER MOLINE: Just a brief question
11 and comment. You know, there's so many folks
12 that are getting their shots outside of the
13 traditional medical setting that I wonder how
14 much of it is actually being captured.

15 I know that when I see a patient I'm
16 being asked if they've had the flu shot, and then
17 if I'm not administering it, to record without
18 ordering. But I don't know how many people are
19 actually doing it, because it's a bit wonky to do
20 that rather than just order it and have it
21 administered that day.

22 But how many folks, how many people

1 are we missing in this, because you go to any CVS
2 or any drugstore now, and it says flu shots are
3 available, so these data are going to be missed
4 because the health plans are not administering
5 it. And unless someone comes in during the flu
6 shot time for an evaluation, then the data will
7 be missed because they've gotten it elsewhere.

8 MEMBER HILL: Indeed, we're seeing a
9 lot of free vaccines done in North Texas, and a
10 lot of employees who are getting free vaccines,
11 and so it's just not accessible through
12 administrative data the way you might think.

13 So patient's report is almost where
14 you end up just by virtue of the fact that we
15 have made it so accessible. We even have RNs in
16 Texas who can receive lots of vaccine and
17 vaccinate in their community centers, and we see
18 that happening with no administrative billing
19 records.

20 MS. WILLIAMS-BADER: And I would just
21 say that's exactly why we use the survey question
22 because it is, if they are getting it in any of

1 those non-physician settings, the measure is
2 going to capture that.

3 MS. MUNTHALI: Matt.

4 MEMBER STIEFEL: Sorry to beat this
5 dead horse of race and ethnicity, but it's a
6 little different in this case because we're
7 talking about CAHPS as opposed to HEDIS.

8 The rationale for HEDIS is that plans
9 don't collect this information. For CAHPS, this
10 is a situation where there are known disparities
11 by race and ethnic groups, and it's -- the issue
12 for CAHPS is that NCQA doesn't gather that
13 information.

14 So I think the recommendation should
15 even be stronger than for CAHPS, that that
16 information is valuable.

17 MS. MUNTHALI: Barry-Lewis.

18 MEMBER HARRIS: I just wanted to make
19 a comment that it's not difficult for me to wrap
20 my mind around a disparity of what is considered
21 a majority population, particularly with the area
22 that I work in in Tennessee, Mississippi and

1 Arkansas.

2 So it just depends upon where you are
3 and then the SES of that particular area, so it
4 may not necessarily be what may be seen as
5 mainstream that could have a disparity, because
6 disparities exist wherever there is a gap in
7 care, no matter who it is.

8 And so we should always think about
9 just the, in population health, who is not
10 receiving the care so we can reach whoever they
11 are.

12 MS. MUNTHALI: Great. Other comments
13 from the committee?

14 I think we're ready to vote on
15 performance gap for Measure 0039. This, one is
16 high, two is moderate, three is low and four is
17 insufficient, and we're looking for 14 votes.
18 Thanks. Thirteen, somebody stepped out.
19 Actually 12.

20 (Voting.)

21 MS. MUNTHALI: So for high, 11 voted
22 high; 1 voted moderate, so this measure passes on

1 performance gap. So we'll move on to
2 reliability. Catherine.

3 MEMBER HILL: So now we're going to
4 look at reliability, which requires that the
5 measure produce consistent reliable and credible
6 results about the quality of care when
7 implemented, the level of analysis at the health
8 plan level and integrated delivery system level.

9 The numerator here is those aged 18 to
10 64 of the Medicare or commercial CAHPS survey who
11 report having received an influenza vaccine since
12 July of the previous year, and the respondents
13 65-plus years to the Medicare CAHPS survey who
14 report having received an influenza vaccine since
15 July of the previous year.

16 The denominator is Medicaid commercial
17 CAHPS respondents and Medicare CAHPS respondents.
18 The developer notes a change in measure
19 specifications for both groups where they had
20 changed the wording from "have you had a flu shot
21 since September 1st" of a particular year to
22 "have you had either a flu shot or flu spray in

1 the nose since July 1st" of the specified year.

2 The developer also noted changes to
3 the measure specifications for the younger age
4 group and expanded the age range from 50 to 64 to
5 18 to 64 to align with the current ACIP
6 guidelines and added Medicaid product line to the
7 eligible population.

8 Both of these changes were reviewed
9 and vetted through a public comment period and
10 approved by the Committee on Performance
11 Measurement and Board of Directors.

12 The question before the committee is
13 are all the data elements clearly defined; are
14 all appropriate codes included; and is this
15 likely to be consistently implemented?

16 MS. MUNTHALI: Thanks, Catherine.
17 Michael, anything to add?

18 MEMBER BAER: I have nothing to add.
19 I mean if you wanted me to -- you know, as far as
20 those questions are concerned, I can, you know,
21 since it's a survey, we don't need to have any
22 codes, so I think the data elements are clearly

1 defined, and I think it's consistently
2 implemented because it's a CAHPS survey.

3 So I think that, you know, would
4 really lend itself to consistency, so that's all
5 I have to comment on.

6 MS. MUNTHALI: So thank you. Because
7 this is a maintenance measure, the information,
8 the new testing information NCQA supplied for
9 reliability is directionally the same as it was
10 when they brought the measure up for maintenance
11 in 2012.

12 So the committee can opt not to re-
13 vote and just accept your last decision on the
14 measure with regards to reliability. Are you
15 okay with that? Heads are shaking yes.

16 So we'll move on to validity, and
17 Catherine and Michael, anything you'd like to
18 mention for the group?

19 MEMBER BAER: I would like to just
20 comment, Catherine, if you don't mind. You know,
21 when they talked about validity testing and
22 performing the empirical test on stakeholder

1 volunteers, I didn't know if the definition of
2 volunteers could be clarified.

3 Were these folks who were
4 representative of the populations being
5 administered the survey, or who were they?

6 MS. MUNTHALI: Mary and Jenna.

7 DR. BARTON: Sure. So we endeavor to
8 include in our cohort -- when we suggest a change
9 to the CAHPS consortium, just so you could
10 appreciate the steps here, we do the testing in a
11 population absolutely that is representative of
12 the population who are answering the survey, and
13 we're working with endeavoring to match reading
14 level, age group kinds of comprehension issues,
15 and that is the process that we went through in
16 this change.

17 I think that the bigger question,
18 going back to both what Tom and Steve were
19 talking about, is that there are guideline
20 changes that come out at the time when FluMist
21 was first recommended for adults, you know, then
22 the folks sort of scurry to update the wording

1 and get the CAHPS consortium to include an
2 updated question.

3 And now we're, you know, we're in a
4 situation where CDC is saying, oh, well, maybe
5 not this year. Don't do it this year.

6 So that's, you know, to the point of
7 the process that we used, we used what we
8 understand to be all of the best techniques for
9 cognitive testing of the item.

10 MEMBER BAER: Great. You've answered
11 my question, and I appreciate that. In fact, I'd
12 rather see the, you know, keeping the language
13 the way you have it now as, you know, if we
14 happen to have a change in the recommendation
15 next year and it does include the nasal spray,
16 then you've already got it there, and you don't
17 need to add it, so thank you.

18 MS. MUNTHALI: Other comments on
19 validity?

20 MEMBER HILL: And so there are no
21 meaningful trends in the missing data on this?
22 It looked like there was one committee comment.

1 It was concerned about missing data.

2 MEMBER BAER: I can just -- I don't
3 know if that was my response.

4 MEMBER HILL: Yes.

5 MEMBER BAER: I don't know if I can
6 interject.

7 MEMBER HILL: Yes.

8 MEMBER BAER: I think we talked about
9 ethnicity and race, you know, being not collected
10 and potentially being missing data, but I think
11 we've already discussed that. So I didn't have
12 anything further on it.

13 MS. MUNTHALI: I think Mary and Jenna
14 were looking up something, or is that --

15 MS. WILLIAMS-BADER: Well, I think we
16 were just trying to figure out exactly what the
17 question was about the missing data.

18 MS. MUNTHALI: That there wasn't any
19 information on it, and so they wanted to know if
20 there was any significant impact of there not
21 being any information on the missing data.

22 MS. WILLIAMS-BADER: We don't get

1 information about missing data per rate.

2 MS. MUNTHALI: Any other questions?

3 CHAIR McINERNEY: By the way, I did
4 pull up a CAHPS survey,/k. and it does ask at the
5 end of the survey about race and ethnicity. Now
6 it's possible that the person who fills out the
7 survey may not answer that question or those
8 questions, but it does ask at least.

9 MEMBER STIEFEL: And does NCQA look at
10 that?

11 DR. BARTON: We don't currently get
12 it, but I think we can ask for it. And my
13 understanding is that it is variably filled out,
14 not highly complete, but there's no reason why we
15 couldn't try to correlate the race and ethnicity
16 that is reported with the response to the
17 vaccination questions.

18 MS. MUNTHALI: Okay. It doesn't look
19 like there are other comments or questions so
20 we'll go ahead and vote on validity. One is
21 high, two is moderate, three is low and four is
22 insufficient.

1 (Voting.)

2 MS. MUNTHALI: It looks like we need
3 four more votes, so if you can re-vote, point
4 your clicker to Sheila or Diane.

5 CHAIR MCINERNEY: We're in Chicago; you
6 have to vote often.

7 MS. MUNTHALI: So we're at 13. So 6
8 voted high; 7 voted moderate, so the measure
9 passes on validity. We will go on to
10 feasibility, so Catherine and Michael.

11 MEMBER HILL: On feasibility, the
12 question is to what extent do the specifications
13 including measure logic require data that are
14 readily available or could be captured without
15 undue burden and can be implemented for
16 performance improvement?

17 The developer reports that the CAHPS
18 survey is conducted by third-party vendors via
19 telephone, mail, email or mixed protocols and
20 that there is concern that many Medicare
21 beneficiaries do not have access to a computer or
22 internet to complete the survey in electronic

1 format.

2 There's also a concern that moving to
3 an internet-based mode of administration would
4 bias the results as older, more frail adults may
5 be less likely to complete the survey. Some data
6 elements are in defined electronic fields for
7 electronic source.

8 The question before the committee is
9 what is the burden of data collection for this
10 measure, and the preliminary rating for
11 feasibility is moderate.

12 MS. MUNTHALI: Michael, anything to
13 add?

14 MEMBER BAER: No. I have nothing
15 further to add. Thanks.

16 MS. MUNTHALI: Comments from the
17 committee?

18 I think we're ready to vote on
19 feasibility for 0039. One is high, two is
20 moderate, three is low, and four is insufficient.

21 (Voting.)

22 MS. MUNTHALI: For feasibility, 6

1 voted high; 7 voted moderate, so this measure
2 passes on feasibility, and we'll move on to
3 usability and use. Catherine and Michael.

4 MEMBER HILL: All right. So usability
5 and use is where we're looking at accountability
6 and transparency. And let's see what I've got
7 here.

8 There are related measures, as we have
9 implied in earlier conversations, such as
10 preventive care screening, influenza immunization
11 in the end stage renal disease population and
12 other flu measures, as well as the percent of
13 residents assessed and appropriately given the
14 seasonal vaccine.

15 The developer has noted that this
16 measure is not completely harmonized with other
17 related measures, as this measure is the only
18 measure to collect information through a patient
19 survey, and they don't view this measure as
20 competing with other measures because of its
21 source of a survey.

22 It has been observed that the other

1 measures are complementary to each other, and
2 each of course confers some protection from
3 getting influenza.

4 The 2012 NQF committee had suggested
5 a universal measure that incorporated all of the
6 various populations included in the influenza
7 immunization measure. That's all I've got to
8 offer.

9 MS. MUNTHALI: Great. Any comments?

10 MEMBER BAER: I'm Mike. No, I did not
11 have any further comments.

12 MEMBER BIALEK: I have a question
13 about the impact of the measure as a result of
14 the plans. So in the past, most of the
15 vaccinations would have been provided by the
16 plans, and as mentioned earlier, CVS and others
17 are providing it.

18 So are there any data that you
19 provided that show patient X not vaccinated at
20 the time originally coming in and later on
21 vaccinated as a result of the plan?

22 So I'm wondering if the plan, in terms

1 of usability, are we measuring the impact of the
2 plan, or are we measuring just the individual who
3 chooses to become vaccinated anywhere? Like is
4 there a way to know the impact of the plan on the
5 individual?

6 MS. WILLIAMS-BADER: I would say no,
7 there isn't a way to know what the impact is, but
8 the plans certainly have a role to play in
9 helping members to get vaccinated. They have
10 different tools at their disposal to make sure
11 that members are getting vaccinated.

12 So just like with any of our other
13 plan-level measures or even physician-level
14 measures and other measures of looking at
15 different levels of accountability, I'd say it's
16 hard to tease out exactly what is, you know, what
17 exactly is the cause and effect of the plan
18 getting the member vaccinated.

19 But we do at least think that this is
20 within a plan's control to impact the rate, and
21 that's what is most important is that they can
22 actually impact the rate.

1 MEMBER HILL: So from a harmonization
2 perspective, what is our risk of over-measuring
3 or measuring someone multiple times without
4 really having an advantage, since there are
5 additional, you know, other sources of this
6 information being collected, related or competing
7 measures?

8 MS. WILLIAMS-BADER: Well, again,
9 because this is a health plan-level measure, it's
10 a population-level measure, I would say one of
11 the advantages that it has or a way it
12 complements other measures is that it's going to
13 -- that plans can reach out to members who are
14 not coming in and seeing physicians.

15 So if you have a physician-level
16 measure, physicians certainly can have an impact
17 but only if the patient comes in. Whereas a
18 health plan-level measure, they can be reaching
19 out to their members who aren't interacting in
20 other ways with the health care system and
21 reminding them about the importance of getting
22 flu vaccination and perhaps pointing out to them

1 where they can get vaccinated.

2 DR. BARTON: And I would just want to
3 add that in looking at the other measures, the
4 population, the general population who are
5 indicated for a flu shot is so much larger than
6 most of those measures that apply to specific
7 settings that it's hard to imagine how, you know,
8 measuring only the ESRD population would be an
9 adequate way to assess a health plan's
10 responsibility to their members.

11 MEMBER HILL: I was noticing on the
12 0227 it just says influenza immunization.

13 MS. MUNTHALI: So I'm glad you
14 mentioned harmonization and related and competing
15 measures. So what we're asking the committee to
16 do is evaluate each measure that's in front of
17 you on its own merits.

18 And on day two, tomorrow, at the end
19 of the day after we've evaluated all of the
20 measures that might be related or competing, we
21 will then look at the differences and, you know,
22 talk about data source and all of that.

1 So we're just looking at this measure
2 for now, evaluating it on its scientific merits.

3 MEMBER HILL: Thank you.

4 MEMBER BAER: So I'd just like to make
5 a comment on something that has just been
6 mentioned about the plan affecting the flu shot
7 rate and getting the patient into care.

8 I think the biggest, the one, the
9 biggest single influencer of someone getting the
10 flu shot is the physician advising the patient to
11 get the flu shot.

12 So the plan can get the patient to the
13 appointment, but unless the doctor's advising the
14 patient to get the flu shot, it may not be in the
15 plan's control to get that patient the flu shot.
16 So I'll just put that out there that, you know,
17 that there is a physician responsibility for
18 advising the patient to get the flu shot.

19 MS. MUNTHALI: Thanks, Michael. Any
20 other comments before we vote?

21 Okay, so for measure 0039, usability
22 and use, high, one; two, moderate; three, low;

1 four, insufficient information.

2 (Voting.)

3 MS. MUNTHALI: Okay, so 6 voted high;
4 7 voted moderate, so this measure passes on
5 usability and use. For overall suitability for
6 endorsement your options are one, yes; two, no,
7 and Sheila's queuing up the slides.

8 (Voting.)

9 MS. MUNTHALI: More votes, one more if
10 you can click again. So 12 yes, 1 no. This
11 measure is recommended for endorsement. Thank
12 you all.

13 What we're going to do is change the
14 schedule a little bit. Lunch is here but we're
15 behind, so, but you did very well, but we're
16 still behind. We have a lot of measures in front
17 of us.

18 So what we're going to recommend is
19 that we have a working lunch for about 15
20 minutes. We ask that you get your food and you
21 can sit in the back if there's room, but
22 definitely sit here or in the hallway. And we

1 reconvene at 12:45.

2 But before we do that, we have public
3 and member comments, so we want to see if there
4 are any of our members or members of the public
5 on the phone that would like to say something, or
6 anyone in the back of the room.

7 OPERATOR: Thank you. At this time,
8 if you'd like to make a comment, please press
9 star then the number 1 on your telephone keypad.
10 And there are no public comments over the phone
11 at this time.

12 MS. MUNTHALI: There are no comments
13 in the back, so we can break for lunch. 12:45
14 we'll be back. Thanks.

15 (Whereupon, the above-entitled matter
16 went off the record at 12:25 p.m. and resumed at
17 12:48 p.m.)

18 MS. MUNTHALI: Hi everyone. We're
19 going to get started.

20 CHAIR MCINERNEY: Thank you, everyone,
21 for reporting back promptly, and we'll continue
22 now on our working lunch with consideration of

1 our next maintenance candidate measure, 000226.

2 MS. MUNTHALI: And so, Operator, I
3 just wanted to make sure that Lisa McGonigal's
4 line is open.

5 OPERATOR: It is.

6 MS. MUNTHALI: Hi, Lisa.

7 DR. MCGONIGAL: Yes, hi. Can you guys
8 hear me okay?

9 MS. MUNTHALI: We can hear you just
10 fine.

11 DR. MCGONIGAL: Great, thank you.

12 MS. MUNTHALI: Lisa, can you just give
13 a background on behalf of your developer team?

14 DR. MCGONIGAL: Yes, I will. Again
15 I'm Lisa McGonigal, and thank you all for taking
16 the time today to review this measure.

17 Again it is NQF's measure number 0226,
18 Influenza Immunization in the End Stage Renal
19 Disease Population which was developed by the
20 Kidney Care Quality Alliance, or KCQA, so I'll
21 just provide a very brief overview for you.

22 So unlike the other measures that

1 you've reviewed already today, this measure is
2 specified for assessment at the level of the
3 dialysis facility. It applies to all end stage
4 renal disease patients aged 6 months and older,
5 and as with the other flu measures that you've
6 been discussing the measure is entirely
7 consistent with NQF's standardized specifications
8 for influenza vaccinations as well as with the
9 current recommendations from the CDC Advisory
10 Committee on Immunization Practices.

11 To illustrate the importance of the
12 measure we note that infectious disease is the
13 second leading cause of death among patients with
14 ESRD, and pulmonary infectious mortality
15 including influenza related deaths is tenfold
16 higher in the ESRD population than in the general
17 population.

18 Yet despite this and the longstanding
19 guidelines and recommendations in place that this
20 vulnerable population be routinely immunized,
21 data from our major testing and the most recent
22 United States Renal Data System Report indicate

1 that there is a persistent and substantial
2 performance gap with only 71 percent of ESRD
3 patients receiving the vaccine in the 2012 to '13
4 flu season and there's wide variation in facility
5 performance scores on the measure ranging from 78
6 to 100 percent, both indicating that there's
7 still substantial room for improvement in this
8 aspect of care.

9 In regards to the scientific
10 acceptability of the measure, testing was not
11 redone because the measure is a maintenance
12 measure. However, we'd note that during its last
13 endorsement maintenance review in 2012, the
14 committee rated the measure reliability as high
15 and the validity as moderate.

16 In regards to feasibility and
17 usability, the measure is currently being used
18 for internal quality improvement in dialysis
19 organizations.

20 Additionally, in its proposed rule for
21 the ESRD Quality Incentive Program issued in June
22 of this year, CMS indicated that it's seeking to

1 add an influenza vaccination measure to the
2 program in the future and currently ours is the
3 only NQF endorsed ESRD flu immunization measure
4 that would satisfy this requirement for use in
5 the QIP.

6 The ACIP has also been in discussions
7 with CMS regarding an update to build the
8 necessary data elements into their CROWNWeb data
9 repository system, so it appears and we believe
10 that measure will be incorporated into the
11 program in an upcoming cycle.

12 So finally, we also reviewed the
13 standing committee pre-meeting review evaluations
14 and I just wanted to comment on one that I
15 haven't already addressed in the introduction.
16 This is on the addition of pediatric patients in
17 measure testing or the lack thereof.

18 So the measure received time limited
19 endorsement in 2007 as an adult-only measure,
20 then in 2008 NQF released its standardized
21 specifications for influenza vaccination which
22 included children.

1 And in response to this and on the
2 recommendation to the American Society of
3 Pediatric Nephrology, we did change our
4 specifications but we did not retest the entire
5 measure.

6 We note that date of birth is a
7 standard data field that would not materially
8 affect data collection or testing results, and we
9 did not believe that confirmation of reliability
10 and validity with the expanded applicable age
11 range was warranted.

12 And that's it. Just let me know if
13 you have any questions as you discuss.

14 MS. MUNTHALI: Thank you, Lisa. So I
15 will pose the same suggestion I posed earlier
16 when we were discussing the NCQA influenza
17 measure on whether or not the committee wants to
18 just vote en bloc for the remaining influenza
19 measures on evidence only and then continue with
20 your discussion on performance gap, or in this
21 case since it is a maintenance measure you can
22 opt to just take your recommendation from 2012

1 when the measure was last looked at.

2 So any, no discussion on the evidence
3 given the lengthy discussion we had last time?
4 Okay, everyone's -- well, a lot of people are
5 shaking their heads yes, so we're going to
6 proceed to performance gap. And I think it's Ron
7 and Tom.

8 MEMBER BIALEK: Well, as the measure
9 developer mentioned there is a performance gap
10 of, I think it was 78 percent, 71 percent of the
11 population immunized and demonstrated a gap
12 amongst facilities as well. So the evidence
13 seemed pretty straightforward on that.

14 CHAIR McINERNEY: I don't have anything
15 to add, pretty straightforward.

16 MS. MUNTHALI: Great. Other comments?
17 Okay, it looks like we can vote on performance
18 gap for measure 0226. We're pulling up the
19 voting slides, so this is for performance gap.

20 Okay, so performance gap, 1 high, 2
21 moderate, 3 low, 4 insufficient.

22 (Voting.)

1 MS. MUNTHALI: And we need one more
2 vote, so if you can re-click. We have 13. So
3 five voted high, seven voted moderate and one low
4 so this measure passes on performance gap, so we
5 can go into our discussion on reliability.

6 Ron.

7 MEMBER BIALEK: So the data were
8 specified well for both numerator and
9 denominator. The one question I had and the
10 measure developer mentioned it is that for the
11 testing there were no pediatric data.

12 And I, while the measure developer
13 said they would not think there would be a
14 difference in the recording of and collection of
15 the pediatric data, I didn't know if that's
16 really valid.

17 That was really my main question about
18 the, because the measure includes 6 months and
19 over.

20 MS. MUNTHALI: Lisa.

21 DR. MCGONIGAL: Yes, did you want me
22 to comment?

1 MS. MUNTHALI: Yes.

2 DR. MCGONIGAL: Yes. The measure was
3 tested at the level of the data elements and as I
4 noted the date of birth field is a common
5 standard data element so we did not believe that
6 there would be any issues at all in capturing
7 this reliably.

8 And that it is already known as a
9 valid data element so it would not impact our
10 testing results. As to how it would impact the
11 performance on the measure that's a different
12 story, but it would not impact reliability or
13 validity of the measure.

14 MS. MUNTHALI: Ron.

15 MEMBER BIALEK: Well, the data for the
16 pediatric population would be provided by a
17 guardian or a parent, correct, whereas the data
18 for the other, the adult population we would
19 confirm with the patient themselves, right.

20 So it would seem like there could be
21 some difference, some discrepancy there.

22 MS. MUNTHALI: Lisa, did you --

1 DR. MCGONIGAL: I'm sorry.

2 MS. MUNTHALI: Go ahead.

3 DR. MCGONIGAL: It would depend on
4 whether, if the vaccine is administered at the
5 facility then that is not an issue. But
6 otherwise yes, it would be in many cases
7 confirmed by a patient or guardian.

8 MS. MUNTHALI: Tom, would you like to
9 add anything?

10 CHAIR MCINERNEY: No.

11 MS. MUNTHALI: Okay. Any other
12 comments on reliability testing for 0226?

13 DR. MCGONIGAL: Oh, can I add one
14 additional thing? I'm sorry.

15 MS. MUNTHALI: Sure.

16 DR. MCGONIGAL: Okay. Yes, I just
17 also wanted to add that as far as our experience
18 with other measures in the population that
19 pediatric, it's fairly negligible in the
20 standard. The population is negligible in the
21 standard facility, meaning non-peds based
22 facility.

1 And in fact most facilities, actually
2 I don't think there have been any facilities that
3 have met the CMS threshold of greater than 11
4 pediatric patients to be included in the measure
5 if that's, and that's at this point in time.

6 According to USRDS there are about
7 fewer than 10,000 children being treated with
8 ESRDS.

9 MS. MUNTHALI: Ron.

10 MEMBER BIALEK: Was the gap any
11 greater in the facilities who have a higher
12 proportion of the pediatric population?

13 DR. MCGONIGAL: Are you referring to
14 the gap from testing or from USRDS data?

15 MEMBER BIALEK: I'm sorry, the gap in
16 testing.

17 DR. MCGONIGAL: Yes, we did not test
18 in the pediatric patients so we don't have that
19 information.

20 MEMBER BIALEK: Right, but I'm talking
21 about the -- I'm sorry. The facilities where you
22 show a higher proportion of non-vaccinated or not

1 ask the question was that any greater for
2 facilities that had a higher proportion of
3 pediatric population?

4 DR. MCGONIGAL: No, we did not assess
5 that during testing.

6 MS. MUNTHALI: Other questions or
7 comments?

8 Okay, we're ready for a vote for 0226,
9 reliability. 1 high, 2 moderate, 3 low and 4
10 insufficient, voting is open. We're looking for
11 14 votes.

12 (Voting.)

13 MS. MUNTHALI: Okay, one high, 11
14 voted moderate, one voted low and one
15 insufficient, so this measure passes for
16 reliability and we'll move on to our discussion
17 in validity. Ron and Tom.

18 MEMBER BIALEK: So I had the, really
19 the same issue about the pediatric population
20 when it came to validity testing as well, because
21 that population again was excluded from testing.

22 MS. MUNTHALI: Tom, anything to add?

1 CHAIR MCINERNEY: No, I agree. It
2 would be helpful in the coming years to try and
3 look at what the pediatric population results are
4 as well as the adult and I think there should be
5 ways of doing that. And I would urge the measure
6 developer to look into that please.

7 MS. MUNTHALI: Lisa.

8 DR. MCGONIGAL: Thank you. Yes, and
9 we do want to reinforce again that the testing
10 was performed at the level of the data elements
11 and it's the date of birth data element that
12 we're looking at for pediatrics which is a common
13 data field and should present no issues as far as
14 reliability and validity are concerned.

15 MS. MUNTHALI: Other comments?

16 Okay, I think we're ready for a vote
17 on validity. 1 is high, 2 moderate, 3 low, 4
18 insufficient. Voting is open.

19 (Voting.)

20 MS. MUNTHALI: We need one more vote.
21 You can reselect. One more time. If you can try
22 it one more time. Okay, 14. Zero voted high, 13

1 voted moderate and one voted no, so this measure
2 passes validity. We'll go to feasibility.

3 So Ron and Tom.

4 MEMBER BIALEK: Again what was
5 provided by the measure developer indicated that
6 these data are routinely collected and seem to be
7 feasible to collect.

8 MS. MUNTHALI: Any other comments?

9 I think we're ready for a vote. 1
10 high, 2 moderate, 3 low, 4 insufficient.

11 (Voting.)

12 MS. MUNTHALI: We need one more vote,
13 if you can re-enter your selection. We got it,
14 okay. Six voted high, eight voted moderate, so
15 this measure passes feasibility and so we'll move
16 on to usability and use.

17 MEMBER BIALEK: Yes. Currently being
18 used, identifying gaps, quality improvement can
19 be sold from this as well.

20 MS. MUNTHALI: Okay, great. Any
21 concerns from the rest of the committee,
22 comments?

1 I think we're ready to vote. 1 high,
2 2 moderate, 3 low and 4 insufficient information.

3 (Voting.)

4 MS. MUNTHALI: We got it, 14. Nine
5 voted high, five voted moderate, so this measure
6 passes on usability and use. So now we'll assess
7 the overall suitability for endorsement. 1 is
8 yes and 2 is no.

9 (Voting.)

10 MS. MUNTHALI: We need three more
11 votes.

12 (Voting.)

13 MS. MUNTHALI: Two more. One more.

14 (Voting.)

15 MS. MUNTHALI: Just one more. We got
16 it. So 13 voted yes and one voted no, so measure
17 0226 is recommended for endorsement.

18 Thank you, Lisa.

19 DR. MCGONIGAL: Okay, thank you so
20 much.

21 MS. MUNTHALI: So now we'll call up
22 our colleagues from the CDC for measure 0431:

1 Influenza Vaccination Coverage Among Healthcare
2 Personnel. So I don't know if they're, are they
3 in person or on the phone?

4 MS. LINDLEY: Hi, this is Megan
5 Lindley from CDC. I'm on the phone.

6 MS. MUNTHALI: Hi, Megan. So if you
7 could please give us a two- to three-minute intro
8 of your measure that would be great.

9 MS. LINDLEY: Oh, sure. So this is a
10 facility level measure looking at seasonal
11 influenza vaccination among health care personnel
12 and that's divided into three groups.

13 The first are payroll employees, the
14 second are non-employee licensed independent
15 practitioners whom we define as physicians,
16 nurses in advanced practice and physician
17 assistants, and the third group is non-employees
18 also. It's students and health care trainees and
19 volunteers age 18 and older.

20 All personnel who work in a reporting
21 facility physically during the defined influenza
22 season which is October 1st through March 31st of

1 the following year are included in the measure,
2 so there's no exclusion based on clinical
3 responsibility or patient contact.

4 The numerator categories are
5 vaccination at the facility or outside, medical
6 contraindication, declination and unknown status.
7 This is consistent with the NQF harmonized --
8 excuse me -- consensus standards on vaccination
9 with the exception of that unknown status
10 category which we added to assist facilities in
11 tracking their ability to report.

12 So this measure was last reviewed and
13 endorsed by NQF in May 2012. Since the last
14 endorsements we did make one change. We expanded
15 the denominator. It used to be personnel working
16 30 days or more during the influenza season.
17 It's now personnel working one day or more, so
18 it's actually become more inclusive.

19 And this is based primarily on
20 feedback from facilities regarding feasibility of
21 identifying personnel working 30 days or more,
22 and this is consistent with the specification

1 that we pilot tested so we were comfortable with
2 the change.

3 Our data do show a gap in performance.
4 Looking at the mean vaccination for all facility
5 types there's room for improvement toward the
6 Healthy People 2020 target of 90 percent
7 vaccination.

8 The data also show substantial
9 geographic variation. For just one example, the
10 reported coverage in acute care hospitals in this
11 past reporting year range from 63 percent to 97
12 percent, and then on the state end the variation
13 is consistent across all the facility types that
14 we've looked at and the data do also show
15 variation among those three different reported
16 groups of health care personnel.

17 We did also see some progress for the
18 facility types that have reported for multiple
19 years. They show incremental increases in
20 reported coverage and decreases in the proportion
21 of personnel with unknown vaccination status.

22 And the measure is currently in use in

1 eight CMS quality reporting programs which cover
2 about 16,000 facilities. It began in January
3 2013 for acute care hospital inpatient quality
4 reporting, inpatient rehabilitation facilities,
5 long-term acute care hospital outpatient
6 departments and ambulatory surgery were added in
7 the 2014-15 influenza season.

8 Outpatient dialysis facilities and
9 inpatient psychiatric facilities were added this
10 past season 2015-16, and the PPS-exempt cancer
11 hospitals will be added beginning in the 2016-17
12 influenza season, so the one we're in right now.

13 Thank you.

14 MS. MUNTHALI: Thanks, Megan. As with
15 the other influenza measures just wanted to pose
16 a couple of questions to the committee. Do you
17 want to accept the evidence that you reviewed, or
18 the Health and Well-Being Committee reviewed in
19 2012, or would you like to have discussion and
20 vote on this measure in particular?

21 Jason.

22 MEMBER SPANGLER: I just have a

1 question because -- and I was in here earlier.
2 Sorry, I had to leave for another event. But I
3 think this is the first measure that we're
4 looking at where the dates are present. Is that
5 correct, today, the October to March time frame
6 we're talking about influenza season? Is that
7 right?

8 MS. MUNTHALI: I think the other ones
9 do because those would comport with our standard
10 specifications. Not all of them though, but most
11 of them, yes. Yes.

12 MEMBER SPANGLER: Oh. So I'm just
13 wondering, because like a measure like this, if
14 somebody got their vaccination on April 2nd they
15 would fall out, but do we really want that?

16 I mean do we, I know the evidence
17 around the season and when we have influenza and
18 stuff like that and trying to get a vaccination
19 earlier, I mean, I feel like, you know, I
20 remember a few years ago talking with people from
21 the CDC and they were encouraging people to get
22 vaccinated in August and September.

1 I mean, the earlier they can get the
2 vaccine in -- what's that?

3 No, no, no. But the push was for
4 earlier, earlier, earlier if they could get the
5 vaccine developed. So I'm just wondering if, I'm
6 just bringing up the conversation about the
7 season.

8 If we want to keep the dates just
9 because, you know, it's the same thing with this
10 one. If someone got vaccinated in September,
11 mid-September then they're not considered, and
12 what the committee feels about that.

13 MS. LINDLEY: This is Megan. That's
14 a great clarification and it's a frequent
15 question by our facilities too, so I'm glad you
16 brought it up.

17 The October 1st through March 31st
18 time frame is for the denominator only. The
19 vaccination is beginning as soon as vaccine
20 becomes available for the season, so somebody who
21 is vaccinated in August or September depending on
22 availability would be included.

1 The denominator is fixed in that way
2 to sort define the population and account for
3 potential delays in vaccine availability, but the
4 numerator does allow for early vaccination.

5 You're correct that somebody
6 vaccinated on April 2nd, the very end of the
7 season would not be included because the cut-off
8 for March 31st is the same for the numerator and
9 denominator.

10 MEMBER SPANGLER: I'm sorry, can you
11 clarify that because I'm looking at the numerator
12 and it's referring to the denominator.

13 But where --

14 MS. LINDLEY: This is all personnel in
15 the denominator who were vaccinated and vaccine
16 became available through March 31st.

17 MEMBER SPANGLER: Oh, I see in the
18 parentheses there.

19 MS. LINDLEY: So somebody who is
20 vaccinated -- yes.

21 MEMBER SPANGLER: Or when -- okay,
22 sorry. Thank you.

1 MS. LINDLEY: -- in September and then
2 quit September 29th, they're not counted.
3 Otherwise they are.

4 MS. MUNTHALI: Other comments or
5 questions about evidence or anything that you'd
6 like Megan to clarify?

7 Arjun.

8 MEMBER VENKATESH: I guess it's sort
9 of the same question as Jason's as my read of
10 this though is I see the or when the vaccine
11 becomes available. My guess is that you
12 construct the seasonality but recognizing that
13 providers are going to move between facilities
14 and move around as well.

15 So if you worked at a hospital that
16 had access to vaccine and they gave a bunch of
17 immunizations in September and then you go and
18 you're a traveler and you work at a different
19 hospital three months later, you're going to have
20 a day of work in December and so you'll be
21 captured in that facility or that hospital's
22 IQR/OQR measure for this, but your immunization

1 happened at another hospital prior to the window
2 that's, because my read of this is, you know,
3 when was it available.

4 What if it was only available on
5 October 1st at that facility? Would that mean
6 that that score for that facility is wrong? Like
7 do you need to have the dates on the numerator or
8 could you just take it out?

9 MS. LINDLEY: No, if I'm understanding
10 your question, so in the case of the traveler you
11 cited we would encourage the facility, if there's
12 sister facilities in the similar system we'll say
13 they can use their data systems to pull the data
14 and say the person is vaccinated at the facility.

15 Otherwise they would fall into the
16 other vaccination category which is vaccinated
17 outside the facility and provided documentation,
18 and that documentation would be an attestation by
19 the worker or a form from one facility or the
20 other saying they were vaccinated.

21 So you don't require the date of
22 vaccine availability at each individual facility

1 in order to score someone as having received the
2 vaccine because they can be vaccinated within or
3 outside the facility.

4 Did I understand your question
5 correctly?

6 MEMBER SPANGLER: Yes, thanks. That
7 helps.

8 MS. MUNTHALI: Steve.

9 MEMBER TEUTSCH: I also have a
10 clarification question. It says in the numerator
11 at least that you're included in the numerator if
12 you decline influenza vaccination?

13 MS. LINDLEY: Yes, and I believe --

14 MEMBER TEUTSCH: I mean, it seems to
15 me that you'd want these facilities to get those
16 people. You wouldn't want to exclude them from
17 the -- you don't want to include them in the
18 numerators if they were vaccinated, or do I
19 misunderstand?

20 MS. LINDLEY: No, no, no. And thank
21 you for bringing up that clarification as well.
22 This I also believe is consistent with the way

1 that NQF suggests that vaccination measurement
2 numerators be constructed, so each category is
3 available there for analysis.

4 But the way the data are actually
5 recorded and scored it's only those personnel who
6 receive the vaccine who would be counted in a
7 compliance score and that's what CMS uses.

8 So they're measured, so you could
9 calculate, for example, a declination rate, the
10 declinations over the full denominator, but those
11 people who are contraindicated, declined or
12 unknown would not be counted in a performance
13 score. They're not considered vaccinated
14 obviously.

15 MS. MUNTHALI: And Megan is right, and
16 I just wanted to add to that. In the numerator
17 for our standard specs so we would include the
18 number of persons in the denominator who received
19 influenza vaccine or were assessed and offered
20 but declined the vaccine or were assessed and
21 determined to have had a medical contraindication
22 of that.

1 And then how she says it's reported is
2 different, but we want to make sure that you're
3 assessing that throughout. And then -- does that
4 make sense?

5 MEMBER TEUTSCH: I think it makes
6 sense. It's just, I think it probably could be
7 stated more clearly that you're collecting this
8 information but you're going to actually be
9 reporting it in ways that reflect these different
10 categories, because it sort of sounded like they
11 were going to be aggregated which obviously is
12 not what you wanted.

13 MS. MUNTHALI: Any other questions?

14 MS. LINDLEY: This is Megan. Could I
15 add just one thing for the committee's
16 information?

17 MS. MUNTHALI: Sure.

18 MS. LINDLEY: I think there was a
19 question earlier about the ACIP recommendations
20 for intranasal vaccine but I don't know if it was
21 resolved.

22 And I want to stress here that I'm

1 speaking individually and not on behalf of CDC,
2 but I did find a sentence in, it'd be 2016-17
3 recommendations that says ACIP recommends that
4 LAIV IV not be used during the 2016-17 season for
5 any population. So those too extends to adults
6 as well as children.

7 MS. MUNTHALI: Okay. I think there
8 are a number of clarifying questions so I'm just
9 going to recommend that the committee vote on
10 evidence.

11 So Sheila, if you can pull up
12 evidence. Okay. So 1 high, 2 moderate, 3 low, 4
13 insufficient, and we're looking for 14 votes,
14 right.

15 (Voting.)

16 MS. MUNTHALI: One more. We got it.
17 So five voted high, nine voted moderate so this
18 measure passes on evidence, so we'll proceed to
19 performance gap. Matt.

20 MEMBER STIEFEL: We're in our third of
21 nine flu shot measures, so hopefully we're
22 getting in a groove here.

1 So this is about opportunity for
2 improvement in performance gaps. The developer
3 noted already there are continuing significant
4 performance gaps across types of facilities,
5 across types of personnel and across geographies.

6 The data showed an upward trend for
7 acute care hospitals, but still with remaining
8 opportunity for improvement. The performance
9 across different, the mean performance across the
10 different types of facilities range from 76 to 88
11 percent and the standard deviation ranged from 15
12 to 23 percent.

13 Similar to the other discussions about
14 measures, the disparities data aren't available
15 because the data reported at the facility --

16 MS. MUNTHALI: Thank you. Patricia,
17 anything to add?

18 MEMBER McKANE: No.

19 CHAIR McINERNEY: So we're ready to
20 vote on the gap for this measure, 0431.

21 MEMBER TEUTSCH: Yes. Could I ask one
22 more question before we move to that?

1 CHAIR MCINERNY: Yes.

2 MEMBER TEUTSCH: Matt, you know, it'd
3 be interesting to stratify it by those three
4 groups of different type of personnel. In
5 particular, you care about the people who have
6 patient contact because that's at least how I
7 think of we are primarily trying to protect.

8 Do you have that data that shows the
9 rates by those different groups, because if this
10 were up at 98 percent for those who have contact
11 it seems to me there would be relatively little
12 opportunity for improvement.

13 MS. LINDLEY: We don't measure it by
14 patient contact or clinical duties and the reason
15 is that's not consistent with the ACIP
16 recommendations.

17 The requirement for the denominator
18 that all the personnel measured be physically
19 present in the facility in performing a work duty
20 is what we believe indicates their risk, because
21 they do have the opportunity both to come into
22 contact with patients or be in the patient's

1 room, for example, if you're talking about
2 nutritional services, environmental services that
3 kind of thing.

4 They also have the opportunity to come
5 in contact with each other and transmit influenza
6 that way. So we don't collect and we would not
7 be able to stratify based on patient contact.

8 MEMBER TEUTSCH: No. And so I would
9 think that that would be a useful thing to do,
10 because there are some people who just have
11 purely administrative functions and other kinds
12 of things, and just think about it in terms of
13 where the gaps really are.

14 CHAIR MCINERNEY: You could argue that
15 the administrators should set the tone.

16 MS. MUNTHALI: It looks like we're
17 ready for a vote on performance gap. 1 high, 2
18 moderate, 3 low, 4 insufficient.

19 (Voting.)

20 MS. MUNTHALI: So for performance gap
21 for measure 0431 three voted high and 11 voted
22 moderate so we'll move on to reliability. Matt

1 and Patricia.

2 MEMBER STIEFEL: So in terms of
3 reliability the first question is about the clear
4 specification of the data elements. I guess the
5 only comment I would make is the one that Steve
6 raised earlier about, because it was a little
7 unclear when in the numerator definition it
8 included people who had declined and that was
9 confusing.

10 So I don't know if that's the
11 developer's fault or not, but it would help to
12 clarify that. Otherwise I thought that the
13 numerator and denominator were clearly specified.

14 In terms of reliability testing,
15 that's still part of this one. Yes. There were
16 two types of reliability testing. One was
17 interrater reliability where project staff
18 compared to the raters from the facilities and in
19 three jurisdictions, and the interrater
20 reliability was quite high in two of the three
21 and the third one wasn't as high but that may
22 have been because the project staff didn't have

1 access to the full data from the facility.

2 And there were also key studies done
3 where facilities received vignettes, case
4 studies, and were asked to describe how they
5 would react to different situations and how they
6 would classify people. In both cases the
7 reliability was shown to be high.

8 I guess one thing about the case
9 studies, there were some problematic denominator
10 elements including poor understanding of how to
11 classify physician owners of health care
12 facilities who worked part time and physicians
13 who were credentialed by a facility but had not
14 admitted patients in the past 12 months, and in
15 the numerator some confusion about how to report
16 persistent deferrals of vaccination and verbal
17 declinations.

18 MS. MUNTHALI: Thanks, Matt.

19 Patricia.

20 MEMBER MCKANE: Yes. I think also one
21 of the questions that we were asked, and I'm
22 thinking this is all in the same section, was

1 that is assessed sample adequate for generalized
2 or for widespread implementation?

3 And it was one of the areas that I
4 thought that they did four different, and if I
5 was reading this and understanding this
6 correctly, there were four different sites that
7 were chosen but there really wasn't much
8 geographic variation.

9 And I'm not sure. I think we did a
10 pretty good job about different types of
11 providers, if I'm remembering correctly, and I've
12 gotten these measures a little bit messed in my
13 mind. But, and it's not something I would
14 necessarily hold up or, you know, on this measure
15 about, but I was just curious.

16 I thought typically we liked to try to
17 get more geographic, because there was nobody
18 from this, I think there was no Midwesterner.
19 There was nobody from the Midwest, no facility
20 from the Midwest or from the South.

21 And if that -- and so we're basically
22 to generalize provider population we're assuming

1 that the geographic regions that were selected
2 are representative of the general, of the nation
3 as a whole.

4 MS. MUNTHALI: Jacki.

5 MEMBER MOLINE: There are also state
6 mandates in certain states like New York, which
7 was one of the four they chose, which require
8 health care workers to be vaccinated or wear a
9 mask.

10 California, I believe, has recently
11 passed one or there are some mandates. They may
12 be, L.A. County might have one but I'm not sure
13 if it's throughout the whole state.

14 So I'm looking and seeing that the
15 four states they chose, one of them definitely
16 has had a mandate for at least three to four
17 years or maybe more. One of them has a partial
18 state coverage.

19 So it's also, I don't know if it's
20 truly representative because the data will be
21 skewed somewhat because of a state mandate for
22 health care workers.

1 MS. MUNTHALI: Megan, would you like
2 to address the geographic variation issues that
3 have been raised?

4 MS. LINDLEY: Sure. I think it's
5 correct that they're not necessarily
6 geographically representative. Clearly this was
7 a project where, and I believe this was discussed
8 in our original submission to NQF, the selection
9 of locations for participation was based on
10 interest by the state and an ability to
11 participate.

12 So it was not a scientific sampling,
13 something that was done with no additional
14 budget. Regarding which states were selected,
15 California has a, it's not a strict mandate but
16 they've had a health care personnel offering a
17 documentation requirement, I believe, since 2006.

18 It's correct that New York now has a
19 requirement, but at the time of our pilot testing
20 which was on 2010 that requirement was not in
21 force, so California is the state where you might
22 expect the results to have been skewed or

1 additionally supplemented by the fact that they
2 had a relatively recent requirement to track
3 health care personnel vaccination.

4 We obviously have much more
5 geographically representative data now that the
6 measure is in use across the country. I think
7 the challenge is that the reliability testing
8 which requires in-person validation are looking
9 at a bunch of records. It's extremely resource
10 intensive.

11 MS. MUNTHALI: Thank you. Any other
12 comments?

13 Okay, so we'll move on to a vote. So
14 we should be on validity, right? Did we do
15 reliability? Oh, reliability, sorry. Moving
16 ahead. 1 high, 2 moderate, 3 low, 4
17 insufficient.

18 (Voting.)

19 MS. MUNTHALI: One person voted high,
20 13 voted moderate so this measure passes on
21 reliability. So now we'll move on to validity
22 and I'll ask Matt and Patricia to lead us in

1 discussion.

2 MEMBER STIEFEL: They also did two
3 types of validity testing, convergent validity
4 and face validity. For convergent validity, did
5 kind of an interesting analysis of the
6 correlation between the number of strategies
7 employed to improve the rates, any improvement in
8 the rate, and they found borderline significant,
9 two significant associations between the number
10 of strategies employed and improvement in rates.

11 For face validity they used a Delphi
12 panel in 2011, really just assessing the
13 appropriateness and clarity of the specification
14 of the measure. And in that expert review in two
15 rounds there was strong consensus on the
16 specification of the measure.

17 Patricia, I don't know if you had
18 anything to add.

19 MS. MUNTHALI: Thank you. Any other
20 comments?

21 MEMBER STIEFEL: Oh, just maybe one on
22 the convergent validity. I was intrigued by the

1 method and but though wondered, I suppose you
2 could employ three or four bad strategies versus
3 one good strategy, you know.

4 MS. LINDLEY: That's an excellent
5 point. Just let me clarify that all the
6 strategies that were surveyed and used in the
7 analysis are the evidence-based strategies known
8 to be associated with increased influenza
9 vaccination. So we hope they're all good
10 strategies.

11 MS. MUNTHALI: Okay. So I think we're
12 ready for a vote on validity. 1 high, 2
13 moderate, 3 low, 4 insufficient.

14 (Voting.)

15 MS. MUNTHALI: Need two more votes.
16 One more. Still need one more, if you can
17 reselect. Sorry about that.

18 Okay, so three voted high, 11 voted
19 moderate for validity for measure 0431. So we'll
20 move on to feasibility. Matt and Patricia.

21 MEMBER STIEFEL: I'd just point out
22 that the developer notes that because in many

1 cases clinicians and employees of facilities
2 aren't necessarily part of the electronic medical
3 record of that facility, it's more difficult to
4 capture this information electronically so
5 multiple modes need to be used.

6 And I think they noted some difficulty
7 in documenting verbal declines of staff who
8 verbally declined the immunization.

9 MEMBER MCKANE: And I was also
10 wondering when I was reading through this, in
11 paper records and, you know, what the burden is
12 on the facilities although this is currently, if
13 I'm reading this correctly this is a current
14 measure so this is actually being done.

15 So they are able to do it, but I was
16 just wondering about the burden on facilities if
17 that was, if there's any information about that
18 from the developer.

19 MS. MUNTHALI: Megan.

20 MS. LINDLEY: Oh yes. I think what we
21 have is anecdotal information on the burden,
22 because as part of supporting the measure we have

1 a help desk so we're responding to TAs or
2 queries.

3 We've certainly heard from some
4 facilities and seen in our pilot testing and our
5 published evaluation of the first year of
6 hospital reporting that for large facilities with
7 a lot of staff in some cases this can be
8 burdensome.

9 We haven't received any more of what
10 I would call large-scale burden information that
11 they've really got this deluge of this measure is
12 not possible when we have the 30-day requirement
13 versus the one-day requirement in place for the
14 denominator.

15 So I do think it is, it may be a
16 burden for some facilities. It really is
17 dependent on what kind of system the facility has
18 used, because some of the larger facilities tend
19 to have electronic records for their staff.

20 So it's difficult to say in a cohesive
21 way what we know about burden, and I think there
22 is also an extent to which the more the measure

1 is reported the easier it becomes.

2 So in case of hospitals which have the
3 most employees out of all the reporting
4 facilities, they've now been doing this since
5 January 2013 so I think the burden probably is
6 lessened.

7 MS. MUNTHALI: Thanks, Megan. Any
8 other questions?

9 Okay, I think we can vote on
10 feasibility, 1 high, 2 moderate, 3 low, 4
11 insufficient and we're looking for 14 votes.

12 (Voting.)

13 MS. MUNTHALI: We have 14. Two people
14 voted high, 12 voted moderate and so this measure
15 passes on feasibility. So now we'll assess the
16 usability and use and turn it over to Matt and
17 Patricia.

18 MEMBER STIEFEL: So in terms of the
19 use of the measure it's in widespread use in a
20 number of CMS and Joint Commission programs for
21 facility accreditation and reporting. And we
22 talked about the usability and use of the measure

1 in terms of the variation and the differences
2 across quartiles in performance.

3 Let's see, what else did I have? And
4 in terms of the use of the measure, I think
5 they've been able to show especially in long-term
6 care facilities a demonstrated association
7 between the measure and improved patient
8 morbidity and mortality, which is important and I
9 think it is somewhat unique, more than can be
10 said for a lot of measures where you can actually
11 see a significant outcome improvement from the
12 use of the measure, associated with the use of
13 the measure.

14 MS. MUNTHALI: Thank you.

15 Patricia.

16 CHAIR MCINERNEY: I have a question.

17 Does CMS put any teeth into this by having a
18 disincentive for low rates or do they dock the
19 hospital or other system as they do for some
20 other measures now?

21 MS. LINDLEY: So at this time the
22 measure is part of the quality reporting programs

1 in the pay-for-reporting aspect, so there's a
2 significant disincentive to fail to report. It's
3 a potential two percent decrease in the annual
4 payment update from CMS.

5 None of the measures -- excuse me.

6 None of the programs at this time include this in
7 the value-based purchasing pay-for-performance,
8 so at this time CMS hasn't specified a level of
9 vaccination that needs to be obtained, only that
10 it must be reported.

11 MS. MUNTHALI: Other questions?

12 Okay, we're ready for a vote on
13 usability and use for measure 0431. 1 is high, 2
14 is moderate, 3 is low and 4 is insufficient
15 information.

16 (Voting.)

17 MS. MUNTHALI: So 11 voted high and
18 three voted moderate for usability and use for
19 measure 0431. So we'll proceed to an overall
20 suitability for endorsement vote. 1 is yes and 2
21 is no.

22 (Voting.)

1 MS. MUNTHALI: We need one more vote.
2 Try it one more time. Okay. We have it. So
3 it's unanimous, 14 voted yes for overall
4 suitability for endorsement for measure 0431.

5 So Megan, thank you. Just one thing
6 before we close with this measure. With regards
7 to the NQF standardized specs, what we include
8 and the numerator are that they can be computed
9 and reported separately.

10 So perhaps in revising your measure
11 you might want to add that to clarify some of the
12 concerns that were raised by the committee.

13 MS. LINDLEY: Yes, thank you. And I
14 think we can also specify what the performance
15 score is based on in addition to the numerator
16 element.

17 MS. MUNTHALI: Okay, great. Thank
18 you.

19 MS. LINDLEY: Thank for the
20 opportunity to join.

21 MS. MUNTHALI: Okay, so our next
22 measure for review, it's another influenza

1 immunization measure. This one is from PCP
2 Foundation. It's Measure 0041: Preventive Care
3 and Screening Influenza Immunization. And our
4 developers are in the room, so I'll ask them to
5 come up.

6 MEMBER TEUTSCH: Okay, this is
7 influenza continued.

8 MS. MUNTHALI: Steve, Steve, we're
9 going to ask the developer to introduce the
10 measure.

11 MEMBER TEUTSCH: Oh, I'm sorry.

12 MS. MUNTHALI: That's okay. He's
13 excited.

14 MS. CHAVARRIA: I think he's saying
15 Ron made him do it. So hello, everyone. My name
16 is Elvia Chavarria. I'm with the PCPI
17 Foundation, and I have my colleagues here, Yvette
18 Apura and Diedra Gray, and then we also have our
19 clinical expert, Dr. Stephen Persell, who will be
20 providing the overview. Dr. Persell?

21 DR. PERSELL: Yes, hi, everyone.

22 Sorry I couldn't be there in person. So I was

1 working with the PCPI's work group that made the
2 original version of this measure, and so I think
3 that the highlights of -- so this is a measure of
4 influenza vaccination rate that's suitable for
5 individual clinicians and office practices. And
6 I guess, what level of detail would you like?

7 MS. MUNTHALI: Two to three minutes
8 more, sorry.

9 DR. PERSELL: All right, because I can
10 make it pretty short. So this is basically
11 reporting on patients that are seen in office
12 practice during October through March, and the
13 receipt of influenza vaccination or the
14 documentation of medical, patient, or system
15 reasons for not administering the vaccine.

16 In the data that looked at this,
17 there's still a large gap. Performance is only
18 about 50 percent, and this is substantiated by
19 comparing it to data that the PCPI compared to
20 BRFSS data which looked very similar in terms of
21 the number of adults and children six months and
22 older getting the vaccination.

1 And the other thing that's notable is
2 that there are some gaps between groups, with
3 some non-Hispanic, white minorities getting lower
4 rates of vaccination and adults getting lower
5 rates of vaccination compared with children. And
6 I think that's probably enough from me.

7 MS. CHAVARRIA: Thank you, Dr.
8 Persell.

9 DR. PERSELL: Did you want more of the
10 technical aspects of the measure, or is that what
11 you were looking for?

12 MS. CHAVARRIA: No, I think that's
13 fine. I think we wanted to turn it over to the
14 lead discussants now.

15 MEMBER MOLINE: I have a question, and
16 maybe the discussants -- but it's probably
17 easier. Is this all visits, or is this primary
18 care? Yes, I mean, who -- well, I guess they'll
19 be talking about it with a numerator and
20 denominator, but was it -- that's just a
21 question. When you were developing the measure,
22 was it any visit to a health care provider, or

1 was it -- that's being marked?

2 DR. PERSELL: The measure, my
3 understanding is that this could be applied by
4 groups that seek to evaluate the delivery of
5 influenza vaccination among their care delivery
6 systems. So while we expect a large uptake in
7 primary care, this certainly could be applicable
8 to many other sub-specialties and care settings,
9 but the measure's -- and the measure really is
10 based on the presence of preventive care visits
11 or having two E&M visits.

12 MS. CHAVARRIA: And in the ambulatory
13 center, and then also within home health care and
14 nursing.

15 CHAIR McINERNEY: Can I expand on that
16 a little bit? I think, you know, in many
17 instances, if it's a health maintenance visit,
18 the clinician is liable to ask a patient about
19 immunization status, and if they're not
20 immunized, they would recommend it or give it,
21 but if it's an illness or an injury visit, many
22 times they don't go into that.

1 Now, we have learned that that's a
2 missed opportunity, and in fact, and particularly
3 for flu because of the problem of the seasonality
4 and the fact it has to be repeated every year,
5 that it really -- they should ask about flu
6 vaccine at least for every visit, but I don't
7 know if this captures that or not.

8 DR. PERSELL: So if one were to try to
9 perform well on this measure, one would have to
10 really focus on all visits during the window
11 because one never really knows whether someone's
12 going to have two visits.

13 And so I would say yes, this really
14 strongly encourages clinicians to address
15 influenza during the active season, and it also
16 accounts for the fact that someone could deliver
17 good care, but there's medical exceptions or
18 patient exceptions, namely patients not willing
19 to receive the vaccine, that can be measured and
20 then tracked, and I believe the rates of those
21 exceptions were quite small, only about three
22 percent recorded that.

1 But yes, it gives you a way to track
2 when it's not clinically appropriate or
3 acceptable to a patient to deliver a flu vaccine,
4 but it does really promote it at all visits, even
5 though not every single person that makes one
6 visit will qualify for the -- at least the
7 electronic version of the measure.

8 MS. MUNTHALI: Steve and Katie, any
9 other thoughts on evidence that you'd like to
10 raise for the group?

11 MEMBER TEUTSCH: I think there are a
12 couple of things. One is the point that was just
13 made, that they get triaged by the different
14 reasons is important because, you know, it's
15 important to understand whether there are patient
16 reasons for opting out that need to be dealt
17 with.

18 And I too have the same question about
19 the specialty and the locale of the individual
20 provider because there is likely to be very vast
21 differences between a primary care provider and
22 others, and I didn't see really any breakout or

1 discussion of that issue, and as Tom said, those
2 are all missed opportunities.

3 But it looks like it's both at an
4 individual clinical clinician level as well as at
5 a facility or practice level, so, you know, it
6 would be interesting to see some of those kind of
7 breakouts.

8 MS. MUNTHALI: Matt?

9 MEMBER STIEFEL: It's still just a
10 question about the specification of the measure.
11 So does it count if a person comes in twice
12 during that period and is documented in the
13 electronic medical record of having had an
14 immunization?

15 DR. PERSELL: I believe if you record
16 that a person had an immunization during that
17 season, that that would satisfy --

18 MEMBER STIEFEL: Yes, it's -- oh, I
19 see.

20 MS. CHAVARRIA: Yes, that's right.

21 MEMBER STIEFEL: Okay.

22 DR. PERSELL: It also promotes --

1 helps the clinicians to ask and record vaccines
2 received elsewhere, which is a big problem with
3 flu vaccine measurement, which is that so many
4 patients receive it at work places and places in
5 the community.

6 MEMBER TEUTSCH: I think, Matt, your
7 point is also, if I hear you right, is also an
8 important point, because there is a big
9 difference between getting your vaccination in
10 September or October, and coming in and getting
11 it in March. That's -- you know, you've missed
12 most of the season.

13 So, you know, I think there are some
14 interesting issues regarding timing, although I
15 don't know how to incorporate them into the
16 measure themselves, but if you get it on your
17 second or third visit when you should have got it
18 on your first, that's a problem too.

19 MS. MUNTHALI: Diedra or anyone else
20 from the development team?

21 MS. APURA: I just wanted to remind
22 everyone they are reviewing the registry version

1 of the measure.

2 CHAIR McINERNEY: One other issue on
3 the pediatric side is that for the first time
4 around for influenza immunization, that is
5 between, roughly between six months and two years
6 of age, to be adequately immunized, you need two
7 immunizations with influenza. One is not
8 sufficient. I don't know if your data collects
9 that or not.

10 DR. PERSELL: As currently written, it
11 does not. It does not have a separate criteria
12 for infants and up to two.

13 MS. MUNTHALI: Any other comments or
14 questions on evidence, just on evidence for now?
15 Okay, so perhaps we do take a vote. There are a
16 number of clarifying questions. This is a
17 maintenance measure, but we will vote on evidence
18 for 0041. One is high, two is moderate, three is
19 low, and four is insufficient. Voting is open,
20 and it looks like 13.

21 For Measure 0041, 2 voted high, and 11
22 voted moderate on evidence, so this passes

1 evidence. We'll now discuss performance gap, and
2 I'll turn it over to Steve and Katie.

3 MEMBER TEUTSCH: We already were
4 presented some of the information on performance
5 gaps, and there are some modest performance gaps
6 among all of these different demographic groups,
7 but the biggest thing is there's a big gap
8 between all of them and what needs to be.

9 So there's a big performance gap, less
10 so among, you know, a modest amount for the
11 disparities, and so you get a hint of some of the
12 same anomalies that we discussed under
13 immunization generally.

14 MEMBER SELLERS: I would just add
15 there was a fairly large gap between states too.
16 I saw 39 percent in Florida and 59 percent in
17 South Dakota, so there's a big geographic gap.

18 MS. MUNTHALI: Other comments or
19 questions on gap? Okay, I think we're ready for
20 a vote. One is high, two is moderate, three is
21 low, and four is insufficient, and we're looking
22 for 14 votes.

1 So for performance gap for Measure
2 0041, 11 voted high and three voted moderate, so
3 we move onto reliability. Steve and Katie?

4 MEMBER TEUTSCH: So, I mean, it's much
5 the same as we talked about that. I was a little
6 perplexed here because they used the same
7 information on reliability as they got out of the
8 ESRD. That's what's stated here, and it struck
9 me as a little odd, not that they aren't similar
10 issues, but that it wasn't immediately obvious
11 that that was as relevant. I don't have any
12 particular reason to doubt that you can get this
13 reliably for the same reasons.

14 MS. GRAY: Hi, I just wanted to
15 clarify that the original data that was submitted
16 for testing was from, I believe, 2012. That's
17 the one that included the ESRD data. At the
18 time, we were performing testing using the inter-
19 rater reliability method, which is a lot more
20 expensive.

21 It requires a lot more resources. You
22 have two manual abstractors visiting a site and

1 abstracting the data. So we were trying to
2 multipurpose our data sets, if you will, at the
3 time. We have since submitted some updated
4 testing information that's signal-to-noise ratio
5 analysis, and that was based on 2014 data. The
6 SNR results from the 2014 data were -- okay, so--

7 MEMBER TEUTSCH: You're reporting 80
8 percent reliability when the minimum level of
9 quality reporting advanced 0.99 evaluated with
10 the average number.

11 MS. GRAY: Yes, so the reliability was
12 still high when we performed the signal-to-noise
13 ratio analysis. I think part of the confusion
14 was with the ESRD population being included in
15 the original data, and the fact that the -- I'm
16 not sure if it's always clear when we add in the
17 updated data with the old data. I think
18 sometimes it gets confusing.

19 MS. MUNTHALI: Any other questions
20 about the specifications? Oh, Arjun?

21 MEMBER VENKATESH: So does that mean
22 the safe way to evaluate this is just look at the

1 registry data that is specific to this type of
2 care setting that had signal-to-noise ratio
3 analysis? You can interpret that 0.8 as high and
4 just kind of ignore the kidney disease stuff?

5 MS. GRAY: I'm sorry. Okay, I would
6 need a little bit more clarification on your
7 question.

8 MEMBER VENKATESH: So we're asked to,
9 you know, assess the reliability of this measure.
10 Can we just assess the reliability of the measure
11 based on the data you have from the registry
12 data, which is, I'm assuming, not the ESRD but
13 some sort of office practice registry data, and
14 just ignore the kidney disease stuff from before?

15 MS. GRAY: Yes, sorry. Yes, that was
16 a previous testing project from years ago. So
17 the data that we submitted from 2014 is from the
18 PQRS reporting program.

19 MS. MUNTHALI: Any other questions,
20 comments? So I think we're ready for a vote on
21 reliability. One high, two moderate, three low,
22 and four insufficient. I'm looking for 14 votes.

1 So for Measure 0041 reliability, six
2 voted high, and eight voted moderate, so it
3 passes reliability, and we'll move onto our
4 discussion on validity, and I'll ask Steve and
5 Katie to lead us in that discussion.

6 MEMBER SELLERS: Sure, okay, now my
7 computer is acting up. No, I've got it. Okay,
8 so it's a maintenance measure with new validity
9 testing provided. The specifications align with
10 the evidence. It was tested at the measure score
11 level, and they did face validity only.

12 The face validity was assessed by a
13 nine-member expert panel from the PCPI
14 Measurement Advisory Committee. Committee
15 members were asked to rate their agreement with
16 the following statement: "The scores obtained
17 from the measure as specified will provide an
18 accurate reflection of quality, and can be used
19 to distinguish good and poor quality." It was a
20 five-point Likert scale from strongly disagree to
21 strongly agree.

22 The results of that, of the nine

1 members of the panel, eight members agreed or
2 strongly agreed, and one indicated disagree. I
3 guess as I was reading this, I was just wondering
4 is there any information about the one dissenter,
5 why, you know, what the rationale was for
6 disagreeing. Do you have access to that
7 information?

8 MS. GRAY: I don't, unfortunately. We
9 just asked them to complete the rating using the
10 Likert scale, and sometimes they choose to
11 provide information. In this instance, they did
12 not.

13 MEMBER SELLERS: Okay. There is no
14 risk adjustment. As far as exclusions go,
15 documentation of medical reasons, patient
16 reasons, and system reasons for not receiving the
17 immunization are in the exclusions. As the
18 developer mentioned, the exclusions were about
19 three percent, but I was wondering about the
20 system reasons. An example of that was the
21 vaccine not being available. Are there other
22 system reasons that can be listed?

1 DR. PERSELL: So my understanding is
2 that the element that's reported is, "Not done,
3 system reason," and that the absence of the
4 vaccine not being available is an example, but
5 the exception criteria is just simply, "Not done,
6 system reason",

7 MS. APURA: Other examples of system
8 reasons are, "not entitled to benefits", "drug
9 not available", and other reasons.

10 MEMBER SELLERS: Okay.

11 MEMBER TEUTSCH: Not entitled to
12 benefits? That's almost unheard of these days.

13 MS. APURA: Yes, this, you know, is
14 one of the examples, and there are other -- I can
15 say, "other", here, "patient on waiting list",
16 but, you know, the doctors -- because this one is
17 like, allows clinical judgment, so the doctor can
18 just document reasons that would fall under that
19 bracket.

20 MS. GRAY: So just to add additional
21 clarification, the exceptions, like Yvette said,
22 are to allow for clinician judgment, but also the

1 system reasons really are to ensure that because
2 this is a provider-level measure, that the
3 provider is not penalized for, you know, some
4 larger reason, that the vaccine is not able to be
5 given to the patient.

6 MEMBER SELLERS: And I guess an
7 important distinction to make here between this
8 and the other flu measures is that patient
9 refusal is an exclusion.

10 MS. MUNTHALI: Other comments,
11 questions? Barry?

12 MEMBER HARRIS: And hopefully we're
13 getting ready to vote, but when we get ready to
14 vote, are we going to have the same issue?

15 MS. MUNTHALI: No.

16 MEMBER HARRIS: Okay.

17 MS. MUNTHALI: We changed the number,
18 so what Barry is referring to is, because the
19 highest rating we can give face validity is
20 moderate, so we only included the options you
21 have there. So in the past when we did it the
22 first time and it didn't work, moderate was two,

1 but now it's one. So for moderate, you would
2 vote one, low two, insufficient three.

3 So 13 voted moderate, and 1 voted low,
4 so for Measure 0041, it passes on validity, and
5 we'll move onto feasibility. Katie and Steve?

6 MEMBER TEUTSCH: And I think we've
7 discussed feasibility before, although it's not
8 altogether clear to me that these exceptions are
9 necessarily in the record, but if they are, I
10 mean, then it seems pretty straightforward.

11 MS. MUNTHALI: Okay, it looks like
12 we're ready for a vote on feasibility for 0041.
13 One high, two moderate, three low, and four
14 insufficient.

15 So 10 voted high, and 4 voted moderate
16 for feasibility for 0041, so we proceed to
17 usability and use. Steve and Katie?

18 MEMBER TEUTSCH: Oh, this is already
19 in use in the PQRS primarily. They have the
20 ratings, which are around 50 percent, no real
21 issues, so this is fine.

22 MS. MUNTHALI: So we're ready for a

1 vote, usability and use: one, high; two,
2 moderate; three, low; and four, insufficient
3 information.

4 11 voted high and 3 voted moderate for
5 usability and use for Measure 0041, so we'll move
6 onto the final vote, overall suitability for
7 endorsement: one, yes; and two, no. We need two
8 more votes. It's unanimous. 14 voted yes, so
9 this Measure 0041 is recommended for NQF
10 endorsement. Thank you.

11 So we'll move onto the eMeasure
12 version of 0041. That's measure 3070. Am I
13 correct? Yes, and so for this measure, the
14 evidence base is the same, so what we're going to
15 do is carry over the votes from the claims-based
16 measure, 0041, to 3070, and we'll start
17 discussion on performance gaps.

18 MEMBER TEUTSCH: Yes, I don't know
19 what to say. The numbers that are presented are
20 basically the same as they were before, so the
21 same gaps exist.

22 MS. MUNTHALI: Okay, and Steve, you're

1 by yourself today. John's not with us today, but
2 -- so you're by yourself on this measure.

3 MEMBER TEUTSCH: I have to channel
4 John? That's not going to be possible.

5 MS. MUNTHALI: He'll be here tomorrow.

6 MEMBER TEUTSCH: Okay.

7 MS. MUNTHALI: Okay, any other
8 comments on performance gap? Any questions for
9 the developer? We do have to have a formal vote
10 on performance gap, so we'll tee that up, so one,
11 high; two, moderate; three, low; four,
12 insufficient.

13 Okay, 10 voted high and 4 voted
14 moderate for performance gap for measure 3070, so
15 we'll move onto reliability. This is a fully
16 specified eMeasure, so unlike the trial use
17 measure, so the developers have something to say.

18 MS. CHAVARRIA: Yes, I just wanted to
19 point something out, and this came up with
20 Measure 0041, which is a registry-based measure.
21 In PQRS, it was originally the claims-based
22 measure, and PQRS does not offer the

1 functionality of taking into account two visits.

2 But since this measure is an eCQM
3 being used in the Meaningful Use Stage 2, and it
4 is, in fact, also proposed for use in MIPS, the
5 CMS Merit-Based Incentive Payment System for
6 reporting in 2017, this one actually does -- EHRs
7 actually will provide the functionality to take
8 into account two measures.

9 So the denominator for this measure is
10 just slightly different, and I, of course, made a
11 typo and included the same denominator, but the
12 denominator for this one is actually, and I will
13 read it, "All patients aged six months and older
14 seen for at least two visits, or at least one
15 preventive visit during the measurement period,
16 and seen for a visit between October 1 and March
17 31," which is similar with 0041. So again, this
18 does provide for two visits.

19 MEMBER TEUTSCH: So could you explain
20 the numerator? It says, "doesn't include offer
21 and decline." It doesn't talk about the systems
22 problems. It doesn't talk about patient refusals

1 explicitly. Are those the same?

2 DR. PERSELL: My take on this is that
3 the numerator criteria is delivery of the vaccine
4 or documented receipt of the vaccine in the
5 current season, and then exceptions that are
6 applied if the numerator is not met would be
7 patient, system, or medical reason, so it's not
8 technically part of the numerator criteria.

9 MS. MUNTHALI: So, Steve --

10 MEMBER TEUTSCH: But it is in the
11 electronic medical records that you can
12 distinguish those things?

13 DR. PERSELL: It requires configuring
14 electronic health records to capture these
15 exceptions.

16 MS. MUNTHALI: Steve, what you saw at
17 the top of the page was the staff analysis as we
18 were looking at the NQF standard specifications
19 for influenza vaccine, and so we were pointing
20 out where there was misalignment, and so that was
21 part of it. It wasn't the medical reason, or the
22 patient reasons that you included, but just

1 wanted to note that. Any other questions?

2 CHAIR McINERNEY: Well, I'm a little
3 concerned about just looking at two academic
4 medical centers. We know from other kinds of
5 studies how academic medical centers perform
6 versus how those out in the community --
7 practices are different.

8 Sometimes one is better than the
9 other; sometimes the other way around, and I
10 would think it would be better to do the testing,
11 as some of us who practice in communities, some
12 of us call the real world, versus academic
13 medical centers.

14 MS. GRAY: So, thank you for that
15 comment. I think that there might be a little
16 bit of confusion because the academic medical
17 centers was actually the feasibility testing, and
18 the reliability -- does that say reliability? I
19 can't see that far. Yes, I'm wearing glasses,
20 but I still can't see that. The reliability
21 testing is actually done from a sample from the
22 PQRS program. That's not limited to the two

1 academic centers.

2 CHAIR McINERNEY: Okay, because it says
3 here under reliability there were two academic
4 centers.

5 MS. GRAY: Oh, okay, that must be a
6 typo.

7 MEMBER TEUTSCH: But the reliability
8 that I saw that you're referring to from PQRS, I
9 thought that was the registry data. It looked
10 like at least what we saw here was the same as we
11 saw earlier.

12 MS. GRAY: It's actually different.
13 PQRS allows for reporting via registry option and
14 reporting separately through an EHR.

15 MEMBER TEUTSCH: So you're looking
16 just at the EHR portion?

17 MS. GRAY: Right, so this is just the
18 EHR data, and the reliability results are a
19 little bit different even though they're still --
20 the reliability is still high for the measure.

21 MS. MUNTHALI: Other questions,
22 comments? Okay, so we'll proceed with a vote on

1 reliability for Measure 3070. One is high, two
2 is moderate, three is low, and four is
3 insufficient.

4 We're looking for one more vote. So
5 we're fine, 13. Someone stepped out. So, 8
6 voted high, and 5 voted moderate for Measure
7 3070, reliability, and so now we'll proceed to
8 validity.

9 MEMBER TEUTSCH: I didn't see much
10 evidence from this, and between this and the
11 other measure that we just passed.

12 MS. MUNTHALI: Okay, the claims-based?
13 Other questions or comments? Okay, I think we
14 can vote on validity for Measure 3070, high, one
15 -- we're going to read you that because we
16 brought up the wrong slides. This is, again,
17 only eligible highest vote is moderate, so one is
18 moderate, two is low, and three is insufficient
19 because they did face validity.

20 Okay, 11 voted moderate and 2 low, so
21 3070 passes for validity, and we're going to move
22 onto feasibility. Steve, any comments?

1 MEMBER TEUTSCH: It sort of echoes
2 what Tom said a few minutes ago. The testing was
3 done in a single EHR system and in two academic
4 medical centers, so it's, you know, fairly
5 selective, but, you know, there's no specific
6 issues with it.

7 MS. GRAY: So for feasibility testing,
8 it's a little more difficult to recruit sites to
9 participate in that. We have to identify sites
10 that are not only willing to participate, but
11 sites that have already implemented the measure,
12 plan to implement the measure, and so we
13 recruited the two academic medical centers.

14 We don't have anything to incentivize
15 their participation, unfortunately, so we have to
16 try and charm them, but we got the two academic
17 medical centers and the EHR vendor. It's
18 supposed to kind of serve as a sample.

19 And I know ideally we would be able to
20 include, you know, different clinical settings
21 and more, but I will just say that our testing
22 efforts are ongoing, and so it doesn't stop our

1 recruiting efforts, and our testing doesn't stop
2 at NQF endorsement. We continue to try and reach
3 out and identify participants.

4 MEMBER TEUTSCH: That raises the
5 question, and maybe it's for NQF than for you,
6 why was this not a testing measure as opposed to
7 a -- one that was -- it looks like it's being
8 presented as one that's ready to go?

9 MS. MUNTHALI: Yes, I think this is
10 one of those complicated ones where there's a
11 claims-based measure that's already in a program,
12 and this measure was also in a program,
13 Meaningful Use 2, but it had never come to NQF,
14 and so there was a period -- these are the legacy
15 measures that Jason talked about.

16 We were trying to help the field along
17 while there were requirements out there by the
18 federal government that, you know, they be
19 accompanying electronic clinical measures that
20 accompany the claims-based measures. So we're
21 bringing them back into our process now, and it's
22 a good point.

1 It's a good question about whether or
2 not this should be a trial use measure, but trial
3 use is only -- it only applies to measures that
4 haven't been implemented. This measure
5 technically has been implemented. It just had
6 never come through NQF before.

7 So sitting around this table and
8 evaluating it against our major criteria is new.
9 You did do that for the claims-based measure, but
10 not for the eMeasure. So I'm not sure if that
11 answers your question, but it looks like the PCPI
12 Foundation, they also changed their name, so
13 we're trying to --

14 MS. GRAY: Yes.

15 MS. MUNTHALI: -- get that right.

16 MS. GRAY: There was some confusion.

17 MS. MUNTHALI: So it sounds like you
18 guys are continuing to test in multiple EHRs?

19 MS. GRAY: Yes, our recruitment and
20 identification of test sites and testing does
21 continue. And I would just like to add that we
22 also included, in addition to the feasibility

1 assessments from those three participants, we
2 also included the Bonnie testing, which is
3 hopefully helpful to give you an idea of how the
4 measure would perform in a larger environment.

5 It contains 65 patients, and
6 everything -- we got 100 percent coverage, and
7 all of the patients passed, so hopefully that
8 helps a little bit more and adds more to the
9 feasibility testing.

10 MEMBER TEUTSCH: I read through one of
11 the Bonnie ones. I think this was the one with
12 all of the patients in all of the different
13 sites, and it struck me as if there's some that's
14 okay to go now, and some that were going to be
15 okay in the future. So I read through it, but
16 I'm not sure it was all that enlightening for
17 somebody like me.

18 MS. MUNTHALI: So perhaps what we
19 could do, since you guys are in the process of
20 testing, would you be -- do you think you'd be
21 ready to bring forward testing in another EHR by,
22 let's say, your annual update, so like a year

1 from now?

2 MS. GRAY: Of a different EHR vendor
3 or a different type of setting?

4 MS. MUNTHALI: A different -- well --

5 MS. GRAY: It's a trick question.

6 MS. MUNTHALI: Yes, it is a trick
7 question. I would rather a different EHR vendor,
8 but what can you do in a year?

9 MS. GRAY: We can attempt both of
10 those --

11 MS. MUNTHALI: Okay.

12 MS. GRAY: -- in a year, and hopefully
13 we'll be able to charm some more people to
14 participate in our feasibility testing.

15 CHAIR McINERNEY: Could you scroll up
16 to see where it was tested again, please? Well,
17 you know, when you look at that, a 619 multi-
18 specialty academic medical centers serving 33
19 counties, that's quite a few, and the other
20 academic medical center handles over two million
21 outpatient visits and 40,000 hospital stays.

22 So even though they are academic

1 medical centers, they clearly have outpatient
2 locations in the real world, so that makes me
3 feel a little bit more comfortable with where you
4 had tested the measures.

5 MS. GRAY: Yes, the second entity did
6 or does have over 150 clinics and extensive home
7 care operations, so --

8 CHAIR MCINERNEY: Thanks.

9 MS. GRAY: Thank you.

10 MS. MUNTHALI: Any other comments,
11 questions? Okay, so we'll move forward on a vote
12 on feasibility. One is high, two is moderate,
13 three is low, and four is insufficient. On
14 feasibility, 2 voted high, 10 voted moderate, and
15 one voted low, so for measure 3070, this measure
16 passes on feasibility, so we'll move onto
17 usability and use.

18 MEMBER TEUTSCH: So usability is for
19 the same, all intents and purposes, similar PQRS.
20 It, you know, part of Meaningful Use Stage 2, so
21 not much different.

22 MS. MUNTHALI: It looks like we're

1 ready for a vote. One, high; two, moderate;
2 three, low; and four, insufficient information.
3 So we're looking for two more votes. So for
4 Measure 3070 usability and use, 3 voted high; 11
5 voted moderate, so we'll move onto an overall
6 vote for endorsement suitability: one, yes; and
7 two, no. We're looking for two more votes.

8 CHAIR MCINERNEY: Unlike Chicago, these
9 things are coded so that your vote gets recorded
10 only once even if you vote four or five times, so
11 it's okay.

12 MS. MUNTHALI: So it is unanimous, so
13 Measure 3070 is recommended for NQF endorsement.
14 Thank you.

15 MS. GRAY: We flew in from Chicago, so
16 we understand that you're saying.

17 MS. CHAVARRIA: Thank you, Dr.
18 Persell.

19 DR. PERSELL: Thanks, the weather is
20 very nice in Chicago today.

21 MS. MUNTHALI: So we're making
22 progress. I think we're almost caught up,

1 almost, not quite. So the next measures are also
2 influenza vaccination measures. The first is
3 0680, percent of residents or patients who were
4 assessed and appropriately given the seasonal
5 influenza vaccine, short stay.

6 The steward is CMS and the developers
7 are RTI, and they'll be doing the long stay
8 measure, 0681, soon afterward. So if you could
9 give us a two to three-minute intro to your
10 measure, the first one?

11 DR. BYRNE: I'm here with my
12 colleagues, Amy Helburn and Laura Smith. We're
13 with RTI International, measure stewards for CMS.
14 The cross setting measure, NQF 0680, reports the
15 percentage of short stay residents or patients
16 who were in the facility for at least one day
17 during the most recently completed influenza
18 vaccination season, I'll refer to as the IVS, and
19 who were assessed and appropriately given the
20 seasonal influenza vaccine.

21 The IVS is defined as beginning
22 October 1 or when the vaccine first becomes

1 available, and ends on March 31 of the following
2 year. The measure is the aggregate of three
3 separately calculate sub-measures to reflect the
4 process by which a patient or resident is
5 assessed and appropriately given the influenza
6 vaccine.

7 The three sub-measures are residents
8 or patients who received the vaccine either in
9 the facility, hospital, or outside the facility
10 or hospital, patients or residents who were
11 offered and declined the vaccine, and residents
12 or patients who are ineligible to receive the
13 vaccine due to contraindications.

14 The quality measure 0680 was endorsed
15 for use in the nursing home setting in 2011, and
16 then was expanded for use in the IRF and LTCH
17 settings in 2012. This quality measure is based
18 on the NQF's national voluntary standards for
19 influenza and pneumococcal immunizations.

20 Influenza is associated with increased
21 morbidity and mortality in high-risk adult
22 populations, people with comorbidities, and the

1 elderly. Annual seasonal vaccination is an
2 essential element of a multi-faceted approach for
3 preventing the spread of influenza, and an
4 effective preventive measure against influenza-
5 related hospitalization and death.

6 Public comment and subject matter
7 expert input received on this measure was
8 predominantly supportive of continued endorsement
9 of this quality measure because it improves the
10 quality of care to patients, is not burdensome to
11 implement, and retirement of this measure may
12 result in fewer residents and patients being
13 vaccinated for influenza. The measure is also
14 feasible to implement, with only minor or very
15 rare unintended consequences.

16 The quality measure is based on
17 assessment of nursing home patients, inpatient
18 rehabilitation facility or IRF patients, and
19 long-term care hospital or LTCH patients using
20 standardized influenza items.

21 The influenza data elements used for
22 this quality measure are the same across the

1 instruments, and have been shown to have high
2 reliability and high validity.

3 The denominator consists of the
4 patients or short stay residents, 100 days of age
5 or older, who are in the facility for more than
6 one day during the IVS, and the measure is based
7 on episodes for short stay residents with 100 or
8 fewer days of nursing home care, and for stays of
9 all lengths for LTCH and IRF patients.

10 The quality measure scores for the
11 percent of residents or patients assessed and
12 appropriately given the vaccine for the 2014-2015
13 IVS was 91 percent for IRF, 74 percent for LTCHs,
14 and 81 percent for nursing homes for short stay
15 patients. A very small percentage of residents
16 and patients received the influenza vaccine in
17 the facility, less than nine percent across any
18 of the three settings.

19 About one-quarter of the IRF patients
20 and short stay residents declined the vaccine,
21 and in LTCHs, about 15 percent of patients
22 declined the vaccine. A very small proportion of

1 patients and residents did not receive the
2 vaccine due to medical contraindications.

3 In testing reliability and validity,
4 the results demonstrated acceptable to high
5 reliability and validity of both the data element
6 and the quality measure across each setting. For
7 all three settings, two-thirds or more of
8 facilities had scores that differed from the
9 national mean.

10 We'd like to point out to the
11 committee that we did provide results of testing
12 for the items, or the two influenza items,
13 validity and reliability testing, and have sets
14 of kappa scores for both of the items. Kappa
15 scores were high for the reliability and validity
16 results, and this is based on the testing of the
17 MDS 3.0.

18 For the 2014-2015 IVS, the percent of
19 facilities with a perfect score, meaning all
20 residents and patients were assessed and where
21 appropriate vaccinated, were low for nursing
22 homes and LTCHs, and for IRFs were around 13

1 percent. The between facilities' differences in
2 the QM scores were found to have a small to
3 medium and significant effect on QM scores across
4 the setting.

5 There was a moderate and statistically
6 significant correlation between the short stay
7 and long stay influenza measure for nursing
8 homes.

9 There is opportunity for improvement
10 of this measure by assessing and vaccinating more
11 patients and residents, and reducing the percent
12 of those who decline. We found that 10 percent
13 of IRFs had more than 34 percent of their
14 patients decline the vaccine, and 10 percent of
15 nursing homes had more than 42 percent of their
16 short stay residents decline the vaccine.

17 Disparities in nursing home residents'
18 vaccination status were observed over 10 years
19 ago, and there is continued evidence of
20 disparities in whether post-acute residents and
21 patients are assessed and receive the vaccine.

22 Males, whites, and older individuals

1 were more likely to receive the vaccine, and
2 women, persons of black race, and Hispanic
3 ethnicity, and younger individuals were more
4 likely to decline the vaccine across all of the
5 settings.

6 Further, we did find across the
7 settings that facility characteristics associated
8 with the higher performance, that is in the top
9 10 percent of patients and residents receiving
10 the vaccine, or in the lowest 10 percent of
11 patients and residents declining the vaccine,
12 were found to be smaller sized facilities, more
13 likely to be nonprofit or government ownership,
14 and in rural locations. Thank you.

15 MS. MUNTHALI: Thank you. Marcel, do
16 you want to start the conversation on evidence?

17 MEMBER SALIVE: Okay, thanks. Those
18 last parts, I think, clarify this first section
19 on performance gap. We're not discussing the
20 evidence, right? So --

21 MS. MUNTHALI: Yes, we're saying that
22 for the record. The evidence will carry over.

1 MEMBER SALIVE: Yes, so the
2 performance gap, I think she just mentioned those
3 figures, and I felt they were very constructive,
4 that there are wide differences amongst the
5 facilities in the percent vaccinated, and then
6 there are disparities evident. So, to me, that
7 answers our questions.

8 MS. MUNTHALI: Patricia?

9 MEMBER MCKANE: I agree.

10 MS. MUNTHALI: Okay, so it looks like
11 there are no comments or questions, so we can
12 vote on performance gap, except for Matt.

13 MEMBER STIEFEL: But just this has the
14 same source of confusion for me, that it includes
15 in the numerator those people who declined, so it
16 would just be, I guess, the same clarification
17 for this measure.

18 MS. MUNTHALI: So adding the computed
19 and reported to it as per the NQF specifications,
20 that would help to clarify the confusion.

21 MEMBER SALIVE: So they have composite
22 measures though, so it can be teased out in this

1 case. I thought that it was reasonable.

2 MEMBER MCKANE: I did as well, and I
3 thought -- I appreciated the tables with the
4 analysis that was done showing the percent that
5 refused and all the exclusion factors because if
6 you don't count them, then you're assuming
7 they're like the rest of the population, so if
8 you do show it, then you're --

9 It's the difference between a
10 statistician and an epidemiologist. You know,
11 statisticians are going to love this, so, epis,
12 maybe not so much, but I thought it was -- I
13 appreciated that information in the tables.

14 MEMBER SALIVE: Also, I think you
15 could, you know, take the data, if you're running
16 that institution, and focus your QI on what to
17 look at. So if you have a high amount of
18 refusals, focus on that. If you have a high
19 amount of contraindications, that's probably not
20 really correct, so you could focus on that. So I
21 mean, I think it seemed quite reasonable.

22 MS. MUNTHALI: Any other comments,

1 questions? Okay, so we will vote for Measure
2 0680, one, high; two, moderate; three, low; four,
3 insufficient. So for performance gap for Measure
4 0680, 11 voted high and 3 voted moderate, so
5 we'll move onto reliability, and I'll turn it
6 over to Marcel and Patricia.

7 MEMBER SALIVE: They had, I think,
8 quite a lot of data for the reliability testing,
9 and, you know, it was in the order of many
10 millions of people. So I, you know, it's hard to
11 find a complaint, I think, with that. I was
12 confused a little bit, I think, on the validity
13 testing, but we'll get to that next.

14 MEMBER McKANE: I just, you know,
15 wanted to point out there was a question from the
16 NQF staff, and I just was hoping that somebody
17 could clarify it for me. There was a difference
18 in how the numerator, I believe the numerator,
19 the difference in the specifications between the
20 different hospital types, that the nursing home,
21 I believe they only counted the most recent
22 visit, versus the long-term care hospital and

1 inpatient counted all of the visits.

2 So I was wondering about the
3 difference in how -- it doesn't appear that one
4 was duplicated and one was -- and what was the
5 rationale, a vast difference in data sets, or
6 what the rationale is for that?

7 DR. SMITH: Hi, this is Laura Smith.
8 That's a great question. There is kind of a
9 mixture of reasons, but the primary reason is
10 that the short stay nursing home measure
11 harmonizes in terms of the episode definition
12 with other currently publicly reported nursing
13 home measures on the Nursing Home Compare site,
14 which does use that episode definition and only
15 the most recent.

16 And during the development of the IRF
17 and LTCH measures which are much more recent,
18 within, I guess, was it 2012, that -- the nursing
19 home measures are basically built off of MDS 2.0
20 measures. They're sort of -- we have this, the
21 weight of history, and also there are particular
22 reasons why it's advantageous for the survey

1 process for a nursing home to use that episode
2 snapshot.

3 And so the rationale for the IRF and
4 LTCH development was slightly different in terms
5 of thinking about a post-acute care, very
6 specifically post-acute care measures that would
7 be trying to say, "Okay, every time you have an
8 opportunity to do the right thing, have you done
9 it?" and then also looking at this very specific
10 admission to discharge period.

11 MS. MUNTHALI: So, just wanted to
12 further that discussion. The staff's concern was
13 that we require that measures be specified, they
14 be tested on how they're specified, so all of the
15 settings of care, that they would be specified.

16 We saw that for nursing homes, you did
17 use MDS 3.0 data to test, but there were only two
18 data elements used there as well. Can you talk
19 about your plans for further testing for IRFs and
20 LTCHs?

21 DR. SMITH: Okay, and so that's a
22 separate question than the episode question.

1 Okay, so we have included -- we did include
2 measure-level testing for all three data sets for
3 reliability and validity. That was what we
4 primarily focused on.

5 We also cite data that shows that
6 there is significant overlap in the populations
7 that receive services across long-term care at
8 hospitals, inpatient rehab facilities, and
9 skilled nursing facilities, and so to justify the
10 use of the MDS data.

11 I'm trying to think. Colene, was
12 there anything else that we should add on that
13 discussion?

14 DR. BYRNE: That's a similar
15 population, although I don't believe we should be
16 applying the testing from the MDS to the --

17 MS. MUNTALI: So in terms of the data
18 elements, are you using all of the critical data
19 elements? It's just the two that we saw in
20 there, so we just want to make sure we're not
21 missing anything. So are you saying that they
22 are basically generalizable from MDS to IRF to

1 long-term care?

2 DR. SMITH: Yes, they are identical --
3 so they are identical items, so the item-level
4 testing is not dependent on that episode
5 definition versus stay definition. That's sort
6 of independent because the item-level testing is
7 within a single assessment, and the items are the
8 same across the different settings. There was
9 something else that you had just asked.

10 MS. JOHNSON: We had a question too
11 about your score-level testing that you did.
12 Most of today we have seen kind of the Adams
13 signal-to-noise methodology. You guys have done
14 something a little different for your score-level
15 testing. So I think the question that I would
16 have is just real quickly why did you decide to
17 do it the way you did it?

18 So you were basically testing and
19 looking at how many groups would be significantly
20 above or below the mean, not exactly quite
21 getting to, "Can you differentiate providers?"
22 It's a little bit different question than what

1 you're answering with that analysis, so can you
2 connect the dots for us on that one?

3 DR. SMITH: Sure, so I can't remember
4 the paper exactly, but there -- it may have been
5 a Zaslavsky paper that offered sort of different
6 alternate ways to examine reliability, and one
7 way sort of thinking about reliability is telling
8 you when you're thinking about it, at least at
9 the performance measure level, sort of how much
10 signal is there relative to noise, and so by
11 actually calculating the confidence interval for
12 every single provider, you are actually basically
13 depicting the amount of uncertainty you have
14 around each of those measure scores.

15 And so if you see that once you've
16 actually said, "Okay, the range of confidence
17 around these scores looks like this and relative
18 to the mean," if you're seeing that a lot of them
19 don't overlap that national mean, then it
20 suggests that there is -- there are differences
21 that could be attributable to the characteristics
22 of the provider rather than sort of random noise.

1 It's not as much of kind of where you
2 -- where people tend to go with it, also given
3 that it's somewhat of an intensive way of doing
4 the analyses, but it is something that actually
5 has been recommended as a potential way of
6 examining the reliability of your measures.

7 We did include the eta statistics as
8 well in recognition that different people do
9 things different.

10 MS. JOHNSON: Yes, and Patricia made
11 me laugh with the battle of the statisticians and
12 epidemiologists, but, yes, the eta statistic is
13 actually new to me, so I was just a little bit
14 curious about you did one-way ANOVA. I couldn't
15 tell from your description did you do -- is it a
16 random effects ANOVA? Did you nest within
17 facilities? And is there a problem with having
18 different numbers and patients within each
19 facility when you're doing that kind of analysis?

20 DR. SMITH: That is a good question,
21 and -- yes, so I'm going to throw that to Dan
22 Barch who is on the line.

1 MR. BARCH: Hi, thank you, Laura.

2 It's a random effects, and, well, it's not
3 technically an ANOVA, for just that reason, that
4 we don't have equal N in every group.

5 But it is a generalized linear model,
6 and I believe that our effect is robust to the
7 different assumptions of the ANOVA. And so the
8 fact that we found a significant effect would
9 hold up if we did have equal N and normal
10 distributions.

11 MS. JOHNSON: Thank you, Dan. Your
12 sound is a little bit low in here. Can you
13 repeat that very first sentence that you had.
14 You said it was or was not the random effects
15 ANOVA?

16 MR. BARCH: Okay, sure. Is this
17 better?

18 MS. JOHNSON: Not much, but I'm
19 cocking my ear, I'm trying to pay attention.

20 MR. BARCH: Okay. Yes, it would be a
21 random -- well, the effect doesn't matter so much
22 in the calculation of the eta-squared. That

1 would affect the omega statistic but not -- the
2 eta would be calculated the same way, other way.
3 And also that it's a, this would be a generalized
4 linear model and not actually an ANOVA.

5 MS. JOHNSON: Okay.

6 MR. BARCH: Because you don't have
7 equal N.

8 MS. JOHNSON: Okay, so it was a little
9 bit of mistake in terms of your methodology
10 there. You did not do an ANOVA, you did a
11 hierarchical general linear model of these
12 effects?

13 MR. BARCH: No, no, we -- it is an
14 ANOVA; it's just not, you can't technically call
15 it an ANOVA. But the methodology is, you know,
16 it works the same way with the software. The
17 idea of it is very much an ANOVA. We're looking
18 at within and between group variants.

19 MS. JOHNSON: Okay.

20 MR. BARCH: It's not a hierarchal
21 model in the sense that we're predicting
22 anything.

1 MS. JOHNSON: Okay, got it.

2 MR. BARCH: It's just that very
3 technically it's not -- it's an ANOVA in all but
4 name.

5 MS. JOHNSON: Okay. I think what
6 we'll need to get from you is just maybe the
7 paper that you were talking about from Alan, that
8 talks about if he was -- I know Alan has done
9 inter-unit reliability of the f-statistic. This
10 is a little bit different, but --

11 DR. SMITH: So I can get you the paper
12 for the confidence interval analysis. But that's
13 not the same thing as what -- okay, all right.
14 Just double-checking, because that's not what Dan
15 was talking about.

16 MS. JOHNSON: Right. So we've gotten
17 into the weeds here, but basically what the
18 developers have done is they have done some
19 score-level testing. So from three different
20 data sets from the actual settings where you have
21 specified the data.

22 And because it is, your methods are a

1 little bit different than what we're used to
2 seeing, that's why we're asking them a little bit
3 more detail to try to understand what they've
4 done.

5 So given, in terms of the first method
6 that they did with the differences in means, with
7 the confidence intervals, what you can say there,
8 since you had some that were statistically
9 greater than the mean based on the confidence
10 interval and some that were statistically lower
11 than the mean, you can say that there's at least
12 some providers that are different from each
13 other, right.

14 And that's what we're trying to get at
15 with reliability. We're trying to say, Can you
16 differentiate between providers. It doesn't give
17 you maybe quite the same kind of information as
18 the Adams signal-to-noise that we usually see.
19 It gives you some indication.

20 And then they've done a second method
21 with their eta statistic, with their ANOVA that's
22 not an ANOVA. Again, that is beyond, that's new

1 to me, so, relying on Dan's description of what
2 that is, that would, I think, suffice.

3 It would be an appropriate method,
4 because it is looking at variation between,
5 versus total variation, which is another way of
6 saying what we're interested in with reliability.
7 So apologize for getting into the stats weeds
8 here.

9 MEMBER SALIVE: Since you, you know --
10 since it's a renewal of a measure that was
11 approved before, I mean, they went, I think,
12 pretty far in my opinion. I, you know, despite
13 their confusion to you.

14 MS. MUNTHALI: Yes, they did, but they
15 updated it by adding the two additional settings.
16 And that's why we were concerned. We wanted to
17 make sure that they tested appropriately for
18 those settings of care.

19 MS. JOHNSON: Right, so just to beat
20 it to death.

21 MS. MUNTHALI: They used different
22 data sources. And so we needed to make sure that

1 we can understand what happened in terms of the
2 settings, and to see whether or not they were
3 very complimentary, as they've been saying.

4 But Karen is not really into more of
5 the weeds than we ever get into, so I think we're
6 satisfied.

7 Questions, comments? Okay, so, I
8 think we can vote on reliability for Measure
9 0680. One is high, two is moderate, three is
10 low, and four is insufficient. And I think we're
11 looking, yes, 14 votes, and yes.

12 (Voting.)

13 Two more votes.

14 CHAIR MCINERNEY: Vote again.

15 (Voting.)

16 MS. MUNTHALI: Okay, so consensus is
17 not reached on reliability. We have one high,
18 six moderate, five low, and two insufficient. We
19 will continue voting and resolve this during the
20 post-comment call. So we'll go to validity.

21 MEMBER SALIVE: So validity has, I
22 think, well-specified elements. You know, you

1 were getting into some of that same discussion, I
2 thought, in the stats. I did not see threats to
3 validity that were of concern to me. Did you
4 have comments?

5 MEMBER MCKANE: No, I thought that the
6 validity was fairly good. I thought that, I'm
7 trying to remember this study, but the exclusion
8 criteria were fine. I don't think I really had
9 any questions or concerns with the validity on
10 this measure.

11 MS. MUNTHALI: Any other comments?

12 MEMBER SELLERS: I guess I have a
13 question. Which, you know, when I'm looking at
14 the measure worksheet and I see the staff rating
15 the IRF and the LTCH as insufficient, could you,
16 do you have an update to that preliminary rating,
17 based on the conversation we've already had?

18 MS. MUNTHALI: She's asking for an
19 update, yes.

20 DR. SMITH: So we have, I guess we've
21 talked some about how our rationale for using
22 some of the item-level analysis for nursing home.

1 I think the other area is the face validity,
2 which I think Colene has some talking points to
3 address the face validity question.

4 DR. BYRNE: Well, referring to public
5 comment and subject matter experts. Yes. So we
6 had almost all of the subject matter experts in
7 public comment were very supportive of
8 continuation of the measure, felt that it was
9 important to prove and maintain quality of care.

10 But one of the subject matter experts
11 expressed any concern about the measure.

12 DR. SMITH: And that was based on
13 interviews with seven subject matter experts,
14 with representation across different clinical
15 specialization and settings.

16 DR. BYRNE: Right. I think we had
17 seven public comments. And then we had spoke
18 with around 13 subject matter experts from all of
19 the settings in different disciplines in
20 qualitative interviews.

21 MEMBER MCKANE: I think we, I mean, I
22 think it's a great measure. I think the concern

1 is, is this additional, the long-terms care, I'm
2 going to get the acronyms all mixed up. But the
3 two that were at the nursing home, the two
4 additions, you know, is that going to measure
5 what we want it to measure in the validity?

6 And I think there were some concerns
7 that the staff expressed about how missing data
8 was handled or, you know, about the validity, how
9 validity was tested. And that's kind of what I'd
10 like to hear clarified. And if not today, at
11 least in the future, so I have a little bit
12 better understanding.

13 Again, my stats knowledge is about
14 this big, so. You know, I know it's important,
15 but I just feel like I need a little bit more
16 information on it. I think that, you know, based
17 on just like intuitively, I feel like this is
18 probably a very valid measure. But just to have
19 the proof. Pardon my epi brain.

20 MEMBER SALIVE: Well, to me the
21 settings are, you know, there are some
22 differences technically, but these are other, you

1 know, they have a lot of similarities, the data
2 set that they're filling out for this measure is
3 very similar.

4 So there's no, you know, other than
5 inexperience or something. I mean, I don't know
6 why you would think they would be different.
7 Like, that's what I'm trying to say. And so
8 you've run some of the same analyses. You know,
9 their payment model means they have to fill this
10 data out, right.

11 So it's not like, you know, they have,
12 that's part of how they get the data. So it
13 should be valid, as well as the other source,
14 which we already said was okay.

15 DR. SMITH: I just realized I had one
16 other consensus source to contribute to the face
17 validity, which was the ad hoc review that was
18 done by NQF to expand the measures for IRF and
19 LTCH in 2012. Had seemed slightly tautological,
20 but at the same time, it seems worth mentioning.

21 MS. MUNTHALI: Arjun?

22 MEMBER VENKATESH: I agree with Marcel

1 about the data. Between the two, they are very
2 similar. These are data sets that are, there's
3 plenty of incentives in place to get it right and
4 get all the data. So I'm not as concerned about
5 the long-term care hospital distinction.

6 I guess what I'm left with I think,
7 here, and I'm just trying to summarize this now,
8 like distill to what I can make a decision on is,
9 there's a correlation between performance on this
10 measure and the pneumococcal measure. And so
11 that is sort of moderate, maybe gets a little bit
12 of construct built to the measure.

13 There's no assessment of the measure
14 with an outcome. It's fine, that's not true for
15 a lot of measures. The only real thing that
16 would meet face validity testing, it sounds like,
17 is the 13 experts that were interviewed. I don't
18 think public comments should be used for face
19 validity.

20 I don't think, like you said, I don't
21 think a previous NQF review counts for face
22 validity. But it sounds like you had a 13

1 expert, tech expert panel that reviewed this and
2 said, Yes this has face validity. Because then
3 by that, we would give this moderate, as we've
4 done for other measures.

5 MEMBER SALIVE: I think there was a
6 paper which had real outcome measures, and that
7 was, I cited it in my review. It's in there, and
8 it's from like one million people who got
9 vaccinated. And, you know, and at the
10 proportion, each percentage, higher vaccination
11 resulted in lower hospitalizations for
12 pneumococcal and immunization -- and influenza
13 from that population.

14 To me, that's an outcome measure for
15 this relevant and, you know, it was a published
16 paper out of this same data set. So to me that
17 was strong.

18 MS. MUNTHALI: Any other comments?
19 Karen?

20 MS. JOHNSON: Arjun once again I think
21 hit the nail on the head. This when -- the face
22 validity, I think the question that I had in

1 terms of what you guys did. Let me read you what
2 our guidance is for face validity. Hang on just
3 a second.

4 Face validity, the measure score as a
5 quality indicator may be adequate if accomplished
6 through a systematic and transparent process by
7 identified experts and explicitly addresses
8 whether performance scores resulting from the
9 measure as specified can be used to distinguish
10 good from poor quality.

11 I think it was unclear to us, in terms
12 of what you did for face validity, what did you
13 actually ask your experts. That part is still, I
14 think, a little fuzzy to us.

15 So again, we want to know if you asked
16 them or in some other way got from them their
17 agreement that the measure is able to distinguish
18 good and poor quality. So that's the face
19 validity piece.

20 The score level validity that you did
21 is absolutely fine. It is a form of construct
22 validity. But it was only for the nursing home

1 population.

2 So then the question is, can you or
3 did you do something similar for the IRF in the
4 long-term care hospitals? We didn't see that, so
5 that's why for the IRFs and LTCHs we had
6 insufficient. So those are the two outstanding
7 questions from the staff point of view.

8 DR. BYRNE: The subject matter experts
9 were primarily asked about is the measure
10 important, is there value in the measure, is the
11 measure impacting processes of care, is it
12 resulting in the staff assessing and vaccinating
13 the patients or residents, and about unintended
14 consequences burden.

15 And should the measure, do they
16 recommend that the measure be maintained or
17 retired. And all but one did suggest that the
18 measure be maintained, that it's important that
19 processes are in place, specifically asking about
20 whether it differentiates in terms of care, of
21 providers.

22 That was not a specific question, I

1 think in part because it's a process measure and
2 the evidence, as you said about, you know, how
3 fit improves the care of the patients.

4 There's a general, you know, support
5 for vaccination but not -- we just didn't, you
6 know, ask them if they thought it was good for
7 differentiating quality.

8 MS. JOHNSON: I did want to address
9 Marcel's point about the paper that you talked
10 about. If that paper did actually look at
11 facility level outcomes, so not at the patient
12 level but looking at facilities.

13 If facilities, you know, had higher
14 rates of immunization and therefore had better
15 patient outcomes, I think that absolutely would
16 count in what we would look for as floor-level
17 validation as well.

18 MS. MUNTHALI: Any other questions?
19 Okay, so I think we're ready for a vote on
20 validity for Measure 0680. One is high, two is
21 moderate, three is low, and four is insufficient.
22 Okay.

1 (Voting.)

2 So it's 50-50. So one high, six
3 moderate, four low and three insufficient. This
4 as well is consensus not reached.

5 We will resolve these issues during
6 the post-comment call. And if there's anything
7 the developer can do to clarify their submission,
8 you can do that during this period, during the
9 comment period. And the committee can discuss
10 that. And we'll re-vote on the reliability and
11 validity, and then have a final vote.

12 So we'll move on to feasibility.

13 MEMBER SALIVE: So I think we talked
14 about the element, and it's widely used. So it's
15 very feasible.

16 MS. MUNTHALI: Pat, you agree? Okay,
17 so let's move forward and vote on feasibility for
18 Measure 0680. One is high, two is moderate,
19 three is low, and four is insufficient.

20 (Voting.)

21 Thirteen voted high and one moderate
22 for feasibility for Measure 0680. So we'll move

1 on to usability and use.

2 MEMBER SALIVE: So as I said, it's in
3 the Nursing Home Compare website, and is used
4 there, and also for payment in certain settings.

5 MS. MUNTHALI: Okay, I don't think
6 there are any comments, so we'll vote. Usability
7 and use for Measure 0680, one high, two moderate,
8 three low, and four insufficient information.

9 (Voting.)

10 Two more votes, and one more. So 12
11 voted high and two voted moderate.

12 So because we did not reach consensus
13 on two major criterion, we won't take an overall
14 vote. And we'll work with you on, you know, what
15 revisions you can make by the time the post-
16 comment call comes around.

17 So we'll move right into Measure 0681.
18 It's Percent of Residents Assessed and
19 Appropriately Given the Seasonal Influenza
20 Vaccine, Long Stay. Also stewarded by CMS and
21 developed by RTISA.

22 DR. HELBURN: Thank you. The Long

1 Stay Nursing Home Process Quality Measure, NQF
2 0681, reports a percentage of long stay residents
3 who are in the facility for at least one day
4 during the most recently completed influenza
5 vaccination season, who are assessed and
6 appropriately given the seasonal influenza
7 vaccine.

8 As noted, the IVS begins on October 1
9 and ends on March 31 of the following year. The
10 measure is the aggregate of three separately
11 calculated sub-measures, which are the same as
12 described for NQF number 0680.

13 The evidence of importance of the
14 quality measure is consistent with the Short Stay
15 Cross Setting Quality Measure 0680, and is the
16 same as was already described. Public comment
17 and subject matter expert input was predominantly
18 supportive of continued endorsement of this
19 quality measure.

20 The denominator consists of nursing
21 home long stay residents 180 days of age or
22 older, who have had 101 or more days of nursing

1 home care during the IVS. The national mean
2 facility level score on this quality measure was
3 91.5 percent in the 2013-2014 IVS, and 93 percent
4 in the 2014-2015 IVS.

5 For the 2014-2015 IVS, the percent of
6 nursing homes with a perfect score was 20
7 percent, and 66 percent of residents received the
8 influenza vaccine in the facility, 14 percent
9 declined the vaccine, 11 percent cited having
10 received the vaccine outside of the facility, and
11 less than 1 percent did not receive the vaccine
12 due to contraindications.

13 Testing results demonstrated
14 acceptable to high reliability and validity of
15 both the data element and the quality measure.
16 Sixty-one percent of nursing homes have scores
17 that differed from the national mean in the 2014-
18 2015 IVS.

19 Between facilities, differences in
20 quality measure scores were found to have a
21 medium to large and significant effect on quality
22 measure scores.

1 There was a moderate and statistically
2 significant correlation between the long stay and
3 short stay influenza vaccine measures for nursing
4 homes.

5 As noted, there is evidence of
6 disparities in the overall quality measure, and
7 whether residents receive or decline the vaccine.
8 A small but statistically significant difference
9 was found in the likelihood of being in the
10 numerator by race, Hispanic ethnicity, and age.

11 White and non-Hispanic residents were
12 found to be more likely to be in the numerator.
13 White and older individuals were more likely to
14 receive the vaccine, while black and Hispanic
15 individuals and younger individuals were more
16 likely to decline the vaccine.

17 Opportunities for improvement with
18 this quality measure may be small. The quality
19 measure score has been between 91-93 percent over
20 the last four IVS. In the 2014-2015 IVS, the
21 quality measure score at the tenth percentile was
22 83 percent, and at the 90th percentile was 100

1 percent.

2 However, as observed through the
3 disparities analysis, there are opportunities for
4 improving vaccination rates among black and
5 Hispanic individuals by reducing rates of
6 decline.

7 And there is further room for
8 improving rates of declining the vaccine in that
9 10 percent of facilities, around 1400, have more
10 than 26 percent of their residents decline the
11 vaccine, as compared to 10 percent of facilities
12 that have 0-7 percent decline.

13 Furthermore, analyses of facility
14 characteristics among the lowest and highest
15 performing facilities indicate important and
16 significant facility characteristic differences,
17 with the lowest rates of decline among residents
18 of smaller, nonprofit, and government facilities,
19 and the highest rates among larger, for-profit
20 facilities.

21 Rates of decline were also lower among
22 residents of facilities in rural locations.

1 MS. MUNTHALI: Thank you. So I'm
2 assuming that we're going to skip evidence and
3 accept the prior evidence, and move on to
4 performance gap. Marcel.

5 MEMBER SALIVE: Yes, so I agree that
6 maybe it's a small difference, and 20 percent I
7 guess had about 100 percent rates. But yes, that
8 means 80 percent didn't. So I think there's
9 still some gap. And I believe also the SES and
10 racial disparities were in evidence, as was
11 stated.

12 MS. MUNTHALI: Patricia.

13 MEMBER McKANE: I agree as well. And
14 plus, I think also it's important just because it
15 does seem to be a measure that maybe have a
16 smaller performance gap. It's still important to
17 measure this and to monitor.

18 MS. MUNTHALI: Other comments,
19 questions for the developer? Okay, it looks like
20 we can move on to a vote on performance gaps for
21 Measure 0681. One is high, two is moderate,
22 three is low, and four is insufficient.

1 And we're looking for 14 votes. I
2 think Sheila, you're still setting it up, right?
3 Are you? Oh, you haven't gotten to it. So just
4 a minute.

5 CHAIR MCINERNEY: While we're going to
6 the slide, you know, noncompliance is sort of the
7 flip side of clinician education of patients.

8 And I wonder if, when you're reporting
9 back to nursing homes, those that have higher
10 rates of refusal, does somebody figure out or
11 somebody point out that there are ways to reduce
12 those rates of refusal by working more with the
13 patients and explaining to the patients better
14 the need.

15 Perhaps use some motivational
16 interviewing, those kinds of things that might
17 give you a better compliance rate.

18 MS. MUNTHALI: Thank you. The slide
19 is up now. One is high, two is moderate, three
20 is low, and four is insufficient.

21 (Voting.)

22 We're looking for one more vote.

1 Okay, we got it.

2 One high and 13 moderate for
3 performance gap for Measure 0681, so we'll move
4 on to reliability. Marcel and Patricia.

5 MEMBER SALIVE: So I think it was
6 flagged the same way, but I think there is one
7 slight difference here, which is that this is the
8 long stay measure, and so really people are there
9 for the duration.

10 So I don't think we have any issue of
11 like leaving and coming back or things like -- I
12 mean it does happen, but this is not that group.

13 So I had no concerns. I think the
14 missing data was low and there was, you know, and
15 as was said, you could focus on some of these
16 components again.

17 MEMBER MCKANE: I guess I was
18 wondering why, and I don't know if it's something
19 to do with the algorithm that we're using, why
20 this came out as insufficient. Is it because the
21 algorithm doesn't take into account this type of
22 analysis that was done?

1 Because if we, I mean, you might want
2 to read through this. I think it looks, it
3 sounds good. But then when I go through the
4 actual algorithm, it comes out as insufficient.
5 So just wondering if your staff could comment on
6 that and help me with that.

7 MS. JOHNSON: Yes, well, so one thing
8 to think about when you look at a staff rating of
9 insufficient, that's not always the horrible
10 thing. It might just mean that we didn't have
11 enough that we felt comfortable to be able to
12 mark one or the others.

13 So in terms of their score-level
14 testing, they did the same testing score level as
15 they did with the last measure. So if you were
16 happy with that, then you would be happy with the
17 methodology here. Yes, exactly.

18 In terms of the data element testing,
19 I think the analyst didn't mention -- did you do
20 data element testing for this one as well? Or is
21 it the same?

22 DR. SMITH: Yes, it's the same

1 testing, because it's the item-level testing is
2 independent of whether or not it's a short stay
3 or long stay.

4 MS. JOHNSON: Okay.

5 DR. SMITH: Measure. And so we, so
6 you'll recall Colene reported that there was
7 inter-rater reliability that was done in the
8 development of the MDS 3.0.

9 For both items, they are used to
10 calculate the measure, and the kappa statistics
11 are like nearly perfect when you look at a gold
12 standard to a gold standard nurse. And then
13 something like .8 when you have a gold standard
14 nurse compared to a staff.

15 So we do have definitely have item-
16 level testing for every single item.

17 MEMBER SALIVE: And this doesn't have
18 these other two settings where we had that
19 concern last time. So I think it is much
20 stronger.

21 MS. JOHNSON: Right. Just one more
22 question for you. How many data elements are

1 actually used in this measure? Did your kappa
2 statistics -- you had, what, a couple different
3 kappa statistics, or you had one for numerator,
4 or --

5 DR. SMITH: We have two items that are
6 used for the calculation. We do exclude people
7 based on age, but that birthdate is coming, I
8 think it's coming from like another source than -
9 - I don't think we did testing.

10 Yes, we didn't do testing on the
11 birthdate, if we're going to be really precise
12 about this. But we do have, that gets validated
13 in the submission process for the MDS assessment.
14 So the birthdate should be pretty correct.

15 And then there are two items used for
16 the calculation in this measure. And we did
17 supply four kappas, because of those two
18 different ways that they did the pairings, where
19 you had two trained gold standard nurses and then
20 you had a gold standard nurse and a staff member
21 who actually worked in the participating
22 facility.

1 MS. JOHNSON: Is that clear to
2 everybody? Anybody have any other questions
3 about? Okay.

4 MS. MUNTHALI: So we're ready to vote
5 on reliability for Measure 0681. One is high,
6 two is moderate, and three is low, four is
7 insufficient.

8 (Voting.)

9 So reliability for Measure 0681, one
10 person voted high, nine voted moderate, two low
11 and two insufficient.

12 So this measure passes on reliability.
13 And so we can continue our discussion with
14 validity. Marcel and Patricia.

15 MEMBER SALIVE: So there were minimal
16 threats to validity. The testing was on over two
17 million people. And the paper I mentioned
18 earlier is at the facility level, and so I think
19 this validity is strong.

20 MEMBER MCKANE: I agree.

21 MS. MUNTHALI: Okay. Any other
22 comments, questions for the developer? Okay, we

1 can move forward with a vote on validity for
2 0681. Tom?

3 CHAIR McINERNEY: Validity to only have
4 three, moderate, low, and -- right?

5 MS. MUNTHALI: They didn't here.

6 MS. JOHNSON: Yes, the correlation
7 analysis is at the score level, so high would be
8 an option.

9 MS. MUNTHALI: Yes, it was beyond face
10 validity.

11 CHAIR McINERNEY: Oh, okay. So we can
12 do this way. Okay, I get confused.

13 MS. MUNTHALI: One high, it's okay.
14 One high, two moderate, three low, four
15 insufficient.

16 (Voting.)

17 So one voted high and 13 voted
18 moderate, so this measure, 0681, passes on
19 validity. And we can continue with feasibility.
20 Marcel and Patricia.

21 MEMBER SALIVE: So yes, they generate
22 this data in the process of care in the nursing

1 home and it's highly feasible.

2 MS. MUNTHALI: Any -- well, I guess
3 we're voting. Feasibility, one high, two
4 moderate, three low, and four insufficient.

5 (Voting.)

6 So for Measure 0681, feasibility, 12
7 voted high and two voted moderate. So it passes
8 on feasibility, and we'll continue with usability
9 and use.

10 MEMBER SALIVE: So again, this is in
11 the Nursing Home Compare website and widely used.
12 There was one comment in the report about some
13 people did not like being asked a lot about do
14 they want the flu shot.

15 But that is more of a preference and
16 I would say not a harm. So there is no, you
17 know, untoward happenings from this measure.

18 MEMBER McKANE: Right, and I would
19 just add that I think that it should be
20 continued. There was a question about whether,
21 given its high performance for several years,
22 should it be used to further the goal of high

1 quality, efficient health care, and I would say,
2 Yes it should.

3 MS. MUNTHALI: Thank you. Usability
4 and use for Measure 0681. One high, two
5 moderate, three low, four insufficient.

6 (Voting.)

7 We're looking for one more vote.
8 Okay, for 0681, 11 voted high and three voted
9 moderate, so it passed as usability and use.

10 So now we'll take an overall
11 suitability for NQF endorsement. One yes and two
12 no.

13 (Voting.)

14 So for 0681, the committee, by 13 to
15 1, has recommended the measure for NQF
16 endorsement. So thank you RTI, and we'll be on
17 touch with regard to post-comment.

18 So we have four more measures for the
19 day. We have scheduled a break. We're going to
20 ask if we can cut that break to five minutes so
21 we can get in votes. Should we push forward, or
22 would you like maybe a ten minute break at most?

1 CHAIR McINERNY: Break please.

2 MS. MUNTHALI: So a ten minute break.

3 So we come back at 3:30.

4 CHAIR McINERNY: 3:35.

5 MS. MUNTHALI: 3:35, yes.

6 (Whereupon, the above-entitled matter
7 went off the record at 3:21 p.m. and resumed at
8 3:35 p.m.)

9 CHAIR McINERNY: All right, thanks,
10 everyone, for a short break. And, believe it or
11 not, we are on our last full measure. Yes, 1659.
12 Right?

13 MS. MUNTHALI: Yes, that's it.

14 CHAIR McINERNY: Influenza
15 Immunization for Inpatients.

16 MR. DICKERSON: Good afternoon, and
17 thank you, everybody. Appreciate the opportunity
18 to discuss and review this very important
19 measure. NQF 1659 is a CMS national quality
20 measure in the Hospital Inpatient Quality
21 Reporting Program.

22 It measures the performance rate of

1 eligibility screening for the seasonal flu
2 vaccine and administration of the vaccine, if
3 indicated, for patients aged six months and older
4 who are discharged from acute care hospital stay
5 from October 1 through March 31 of every year.

6 This was originally specified for
7 inpatients with pneumonia. It was re-specified
8 in 2011 as a global hospital measure. Now, there
9 are many opportunities for screening immunization
10 within the continuum of health care provider
11 patient interaction.

12 This measure is the only one that
13 addresses this opportunity in the acute care
14 hospital setting, where patients may be at
15 greater risk than in some other environments.

16 Of note, the CDC recommends offering
17 the influenza vaccine during hospitalizations to
18 avoid missed opportunities. Now, while
19 performance in this measure has increased over
20 time, there are still disparities in some
21 populations of hospitalized patients.

22 This measure is important providing

1 facility-level feedback and maintaining the
2 ability to monitor the performance of the health
3 care system, the prevention of influenza, and
4 complications associated with influenza.

5 MS. MUNTHALI: Great, thank you. So
6 our lead discussants are Barry-Lewis and Jason
7 Spangler. So, Jason, Barry-Lewis. And I know
8 he's one person.

9 MEMBER SPANGLER: Okay, I'm going to
10 start, and then Barry-Lewis can chime in as well.
11 We're skipping evidence, right, again?

12 MS. MUNTHALI: Yes, that's the motion.

13 MEMBER SPANGLER: Just want to
14 confirm.

15 MS. MUNTHALI: Everyone agree?

16 MEMBER SPANGLER: I think Barry-Lewis
17 wants to discuss evidence.

18 MS. MUNTHALI: So we go to performance
19 gap.

20 MEMBER SPANGLER: Yes. So, as noted,
21 the performance gap I thought was kind of
22 interesting. Because it looks like from two

1 different sources that it's not large. But in
2 another context, it seems like it is. It could
3 be up to, you know, 20 percent. So, you know,
4 only 80 percent versus the low 90s.

5 So there is some performance gap. It
6 might be a little higher than others, but it
7 still exists.

8 And then when it comes to disparities,
9 there's definitely some disparities in certain
10 populations. I'm not sure, you know, with the
11 racial disparities it says it's statistically
12 significant.

13 I'm not sure how that corresponds to
14 clinically significant, between 91 and 95. I
15 mean, they're both very high percentages. But in
16 some of the other populations, there's definitely
17 lower percentages in the low 80s, and obviously
18 we want this to be 100 percent. So I would say
19 it's probably, the performance gap, like as you
20 guys stated there, is probably moderate.

21 MEMBER HARRIS: Exactly what he just
22 stated.

1 MS. MUNTHALI: Comments, questions.

2 MEMBER TEUTSCH: Yes, a question
3 though. When you're up around 90 percent, how
4 much better is it going to get? People are in
5 the hospital very short periods of time, they got
6 --

7 MEMBER SPANGLER: It's a great
8 question.

9 MEMBER TEUTSCH: I mean, really,
10 aren't we topping out on this one?

11 MEMBER SPANGLER: I think, it's great
12 question, Steve. I think with other measures if
13 we were at this percentage, we would say, Yes,
14 we're topped out. I don't know if that answers -
15 - but yes, I don't. Because I think, I've been
16 involved in discussions with other measures, and
17 this is where we say we're topped out. But for
18 this, I'm not sure.

19 MS. MUNTHALI: Do others have thoughts
20 on the performance gap or lack thereof? Arjun?

21 MEMBER VENKATESH: I don't remember
22 the exact definitions that are used, but CMS's

1 value-based purchasing program has a couple
2 definitions for topped out.

3 One is I think based on a coefficient
4 or variation. And then the other one, if I
5 remember right, is you compare the 75th to the
6 90th percentile, and see how different those are.

7 I don't see those two here, or maybe
8 I'm not looking in the right place on the form.
9 But maybe that would help give us some general
10 guidance at least.

11 MS. MUNTHALI: Bob, do you have access
12 to those data?

13 MR. DICKERSON: The -- yes, the 75th
14 and 90th percentiles are on the evidence to
15 support the measure. 75th percentile was at
16 .9652 percent, and 90th percentile was at .9978.

17 MEMBER SPANGLER: And there's still a
18 little bit of a gap now. So I guess my question
19 then is, going back to this, and I don't know the
20 exact, it says -- this bullet point here. Yes,
21 you have the second bullet at the top there.

22 For the current submission, the

1 developers saw rates for flu vaccinations and
2 noted that in the flu season, that nearly 10
3 percent of hospitals, one in five indicated they
4 were not vaccinated.

5 So does that mean at the other 90
6 percent of hospitals, it was, I'm assuming higher
7 than that. It was in the 90s or --

8 MR. DICKERSON: Right.

9 MEMBER SPANGLER: Okay. So there's a
10 small percentage of hospitals that have a larger
11 gap than everybody else. That's what we're
12 saying.

13 MR. DICKERSON: Correct.

14 MEMBER SPANGLER: Okay. Do we know
15 anything about those hospitals? Demographics, or
16 is it regional, is it a certain type of, like is
17 it rural hospitals, or something like that? Do
18 we have anything --

19 MR. DICKERSON: I don't have that
20 information, no.

21 CHAIR McINERNEY: Well, one of the
22 questions that I wonder about is, although the

1 gap is relatively small, if somehow we decide not
2 to continue to use this measure because we feel
3 that it's topped out, will that then result in
4 hospitals not continuing to pay close attention
5 to this measure?

6 MEMBER VENKATESH: This is a question
7 related. So when you've got a measure in the --
8 I'm trying to think of what we can do in the
9 confines of this committee. So if we think a
10 measure is nearing being topped out, we're just a
11 steering committee charged with endorsement of
12 the measure or not.

13 And so how do you think about things
14 like use and feasibility in here? Is that, We're
15 not going to touch it because that's the MAP's
16 job? Or, because the way I'm thinking about this
17 on the flip side is it's not a no-work measure.

18 A lot of work happens at hospitals
19 where there's tons of electronic alerts every
20 single time there's a patient hospitalized that
21 says, did you give a flu shot, did you give a flu
22 shot, did you give a flu shot. They're

1 collecting all this data, there's an
2 infrastructure to that submitting it.

3 And so it's not -- should that be
4 figuring into my head of, is it worth this
5 performance gap, given the work? Or are we just
6 going to say, hey, look at the numbers, this is
7 the distribution, is there a gap, and that's the
8 extent of what this committee does?

9 MS. MUNTHALI: So that's a great
10 question, and we're just about to pull up NQF's
11 other, well, its endorsement. But we can -- the
12 committee can recommend this for reserve status.

13 And that means that when you're seeing
14 a measure like this one where you feel that
15 there's very little opportunity for improvement,
16 there's not much of a performance gap.

17 But all of the other criterion are
18 very strong. The evidence, which you already
19 said, the testing, feasibility, use and
20 usability. You can recommend that, you know
21 what, we don't want to monitor this consistently.
22 It's still NQF endorsed. Gets a reserved status

1 labeling.

2 And this committee, as a standing
3 committee, you have oversight over the portfolio.
4 So you may want to say periodically, you look at
5 the measure, see if there are changes in
6 performance or if behaviors have changed as a
7 result of this measure being out there for, let's
8 say, two or three years after it's been put into
9 reserve status.

10 It is still NQF endorsed. It doesn't
11 mean we're removing endorsement. But it just
12 means that perhaps we're focusing our other
13 efforts in other areas, where there may be
14 opportunities for improvement or there's more
15 significant performance gaps. I hope that helps.

16 So what we do, if that's what the
17 committee would like, we would vote on this
18 measure. And the only way that it would end in
19 reserve status, we'd have to go through the whole
20 criteria, is if you voted, let's say low. And so
21 essentially, it's failing or insufficient. And
22 it's failing performance gap.

1 We would then continue, we'd ask you,
2 would you like to consider this for reserve
3 status? And if you say yes, we will continue
4 then with reliability, validity, feasibility, use
5 and usability, and an overall vote. So I guess
6 perhaps more discussion on the gap.

7 MEMBER SPANGLER: The only thing I
8 would want to mention, which seems a little bit
9 significant compared to everything else we
10 discussed is, there does seem to be a gap within
11 the, you know, Native American or Alaskan Native
12 population, compared to everybody else.

13 I mean, everybody else is in the 90s,
14 except for that population. So I don't know if
15 there's anything we can do about that. And I
16 don't know if those hospitals happen to be those
17 hospitals that treat those sorts of patients or
18 anything like that, but I just want to make sure
19 we keep that in mind.

20 MEMBER TEUTSCH: Yes, I like what you
21 said. And I wonder if we can't begin to A)
22 encourage those that remain at the low end to

1 continue to monitor it and work towards
2 improvement. And then call for some time to
3 really revisit this.

4 I mean, maybe you have a regular
5 schedule but, over, you know, three years, five
6 years, whatever the right number is. Because I
7 think his argument's implied. There's a huge
8 opportunity cost from all this stuff.

9 And there are probably higher priority
10 things than trying to goose these hospitals that
11 are already performing well.

12 MS. MUNTHALI: So we can -- the
13 committee can recommend that we look at it, you
14 know, after we have some trend data, perhaps
15 after two or three years. Even when we don't
16 have projects to review measures, we have funding
17 to do maintenance work.

18 That's when we did the updates to the
19 specifications. We worked on the access to care
20 guidance and framework. And so we can look at
21 measures that have been put into reserve status
22 and see if we want to remove that labeling of

1 reserve status in that period as well. Bob?

2 MR. DICKERSON: I would like to just
3 mention something in reference to when we talk
4 about differences and statistical significance
5 and clinical significance.

6 The sample population for this
7 measure, during the time period that reported the
8 data and did the analysis on, was a little over
9 1.5 million cases. And out of those, about
10 92,000 were not screened and/or vaccinated.

11 And if you extrapolate that to the
12 larger population of patients discharged from
13 hospitals during that time, we're talking about a
14 little over a million patients that were not
15 screened.

16 MS. MUNTHALI: Ron has a -- and Matt,
17 I'm sorry.

18 MEMBER BIALEK: I would like to follow
19 up on Jason's comment about the Native American
20 population. Are the Indian Health Service
21 facilities and also the tribal self-determination
22 facilities part of this measure and part of the

1 data collection?

2 MR. DICKERSON: It would be any acute
3 care hospital that's submitting data. So it very
4 well may include some of those. I don't have the
5 exact breakdown on which hospitals. That is
6 something that for future analysis, we could look
7 and see if that data is available.

8 MS. MUNTHALI: Matt?

9 MEMBER STIEFEL: I like the idea of
10 reserve status, and this is how we end up with
11 hundreds of measures, is that measures never get
12 reviewed or retired.

13 Objectively, looking at opportunity
14 for improvement, this is much smaller than any of
15 the other things that we've seen. So if we're
16 just going by this literal interpretation, it
17 seems like very low opportunity.

18 Now, if the gaps are for a small
19 subset of the population, Native Americans or
20 whatever, then perhaps there's a measure related
21 to disparities. But not for an overall measure
22 for all hospitals in the country.

1 MS. MUNTHALI: Jason?

2 MEMBER SPANGLER: Can you provide some
3 clarification? So, the numbers that we see here,
4 with the disparities, is that from the old
5 measure with pneumonia patients, or is that for -
6 - because I see in a couple places it says
7 overall pneumonia patients.

8 So I'm trying to clarify which numbers
9 are from pneumonia patients and which numbers are
10 from all hospitalized or all inpatients. Because
11 that would sway my thinking on the performance
12 measurement gap.

13 Because I would assume that there
14 should be a high -- I'm sorry there should be a
15 low performance gap. There should be, for
16 pneumonia patients, it's more likely I would
17 think that they would get screened and vaccinated
18 versus other patients.

19 MR. DICKERSON: Right, the 2012 data
20 this referenced, and there is from the pneumonia
21 population, that was prior to the measure
22 becoming a global measure.

1 The updated data is, so, under the
2 disparities would be the second bullet point.
3 That comes from the 2014-2015 season.

4 MEMBER SPANGLER: And that's all
5 hospitalized.

6 MR. DICKERSON: Yes.

7 MEMBER SPANGLER: Yes, got it, okay.
8 Thank you.

9 MS. MUNTHALI: Other comments or
10 questions? So again, for reserve status, with
11 NQF endorsement. For that to be an option, you
12 would have to go either low or insufficient, and
13 then we'll have a separate vote that says, would
14 you like to consider this for reserve status.
15 And that's a yes or no.

16 So, the options are high one, two
17 moderate, three low, four insufficient. And this
18 is for Measure 1659.

19 (Voting.)

20 So consensus was not reached on
21 performance gap. So zero highs, seven moderate,
22 seven low, and zero insufficient.

1 So we will proceed to the next major
2 criterion, which is reliability. Jason, Barry-
3 Lewis.

4 MEMBER SPANGLER: So again, this is
5 facilities in the specified dates. I thought the
6 exclusions were well detailed, the specifications
7 are good.

8 One of the issues that they brought up
9 I thought was interesting, it's in the
10 reliability section. It wasn't mentioned in
11 feasibility, I don't know if it applies to both.

12 And I guess this is something that can
13 be resolved. But they noted that there is a lack
14 of an ICD-10 code for a specific influenza
15 vaccination. So basically, instead of getting
16 this from the code, it has to be extracted from
17 the charts now.

18 So that would seem to me not to affect
19 reliability so much, but possibly feasibility.
20 So I thought actually the reliability from the
21 specification perspective was good.

22 The did testing again through kind of

1 signal-to-noise with the binomial model, and it
2 showed pretty high reliability. I think it was
3 .97, which is very high.

4 MEMBER HARRIS: I would just concur
5 with that one point. But I was just wondering,
6 does anyone know any information related to the
7 reason for the drop in the code?

8 MEMBER MOLINE: Do we have
9 confirmation about that? There's 68,000 ICD-10
10 codes, and some of them are so unbelievably picky
11 and obscure, like, you know, water skiing and
12 hurting your knee while you're a prisoner. But I
13 can't believe that they wouldn't have --. And
14 getting it in in front of me.

15 Because I've seen the various codes
16 that I've had to try to find when I'm trying to
17 get rid of my meaningful use nasty box, at the
18 top, regarding whether someone's had influenza.
19 Is there confirmation from anyone else?
20 Catherine? I mean you're doing charts all the
21 time.

22 MEMBER HILL: Yes, I was thinking that

1 was coded using CPT, not ICD.

2 MEMBER MOLINE: It's a CPT not an ICD.
3 Because it's a procedure code.

4 MEMBER HILL: Yes, we pull it up using
5 CPT.

6 MEMBER SPANGLER: But there wasn't an
7 ICD-9 code for that, so.

8 MEMBER MOLINE: But if they're pulling
9 up ICD -- if they're pulling up codes, they can
10 pull up a CPT as easily as they can pull up an
11 ICD-10.

12 MEMBER HARRIS: Right here, it says
13 that the ICD-9 diagnosis V04.81 and V06.6 both
14 will convert approximately to ICD-10 diagnosis
15 code Z23, encounter for immunization. But is
16 that going to be specific for influenza?

17 MR. DICKERSON: And that's exactly
18 what we found, is while the ICD-9 had a specific
19 code for influenza immunization, for whatever
20 reason, when the decision was made of the
21 transfer of the ICD-10s, there are two general
22 immunization codes for any immunization given in

1 the hospital setting. They aren't specific to
2 influenza immunization anymore.

3 MEMBER BAER: So the question would be
4 if the inpatient claim would have the CPT code on
5 it, if the ICD-10 is not specific, does the
6 inpatient hospital claim have the CPT code which
7 would be specific for it?

8 So I can't answer that question, but
9 maybe that's, you know, something that somebody
10 needs to look into.

11 MR. DICKERSON: Yes, and my
12 understanding was that the CPT codes are not used
13 for hospital admissions. We can check further
14 into that, definitely double check that.

15 One thing that we did find when we
16 discovered that there was no specific ICD-10
17 code, we went back to the previous year to try to
18 identify how many cases were identified for
19 having received the immunization by having an
20 ICD-9 code on their medical record, and it was a
21 very, very small percent. It was, I don't
22 remember the exact number, but it was less than 5

1 percent.

2 MS. MUNTHALI: Great, any other
3 questions? Okay, we can proceed with a vote on
4 reliability for Measure 1659. One is high, two
5 is moderate, three is low, and four is
6 insufficient.

7 (Voting.)

8 Missing two votes.

9 Okay, reliability for Measure 1659,
10 seven voted high, two voted moderate, four voted
11 low, and one voted insufficient. So we are just
12 beyond consensus not reached. So this measure
13 passes on reliability. And we'll go on to
14 validity.

15 MEMBER SPANGLER: So empirical
16 validity testing was done, using the traction,
17 and there's demonstrated a high correlation with
18 both the discharge disposition as well as the
19 immunization status. So I thought overall, it
20 was, you know, pretty good validity.

21 MS. MUNTHALI: Other comments? Okay.
22 Time for a vote on validity.

1 So the highest this can receive is
2 moderate, because empirical testing was done at
3 the data element level, not at the measure score
4 level. So one is moderate, two low, and three
5 insufficient.

6 (Voting.)

7 So for Measure 1659, validity testing,
8 11 voted moderate and three voted low, so it
9 passes. So we'll move on to feasibility. And
10 Jason and Barry-Lewis.

11 MEMBER SPANGLER: Yes, I don't think
12 there are any issues with feasibility. And it
13 seems like maybe we've even resolved the coding
14 thing, so I thought it was pretty high
15 feasibility.

16 MS. MUNTHALI: Other comments?

17 MEMBER HARRIS: The only thing I said
18 that this was a chart abstraction, but it's not
19 an automatic from the electronic health record.
20 There's no way for it to be completely from an
21 EHR, because some of the elements could be
22 potentially overlooked by human error versus

1 automatically generated.

2 MR. DICKERSON: So I know one of the
3 things that is happening right now for this
4 measure is we are looking at respecifying it as
5 an eCQM.

6 One of the things that hospitals have
7 done in terms of trying to more consistently
8 apply the immunization screening is they have
9 built electronic screening processes into their
10 EHRs. So we're currently working with hospitals
11 in a testing system to see what information can
12 truly be extracted electronically.

13 MS. MUNTHALI: Ron?

14 MEMBER BIALEK: So help me understand,
15 with there not being the ICD code any longer that
16 specifies flu vaccination. Oh.

17 MEMBER HILL: Yes, I think he's right,
18 there is the Z23 code. The challenge is it's not
19 specific to influenza anymore.

20 MEMBER BIALEK: Right, so my question
21 is how does this remain feasible without that
22 specificity in the code?

1 MR. DICKERSON: So in terms of the
2 manual chart abstraction they can identify from
3 other documentation that is not like an ICD-10
4 code whether or not they received the vaccine in
5 the hospital.

6 MEMBER BIALEK: So when the testing
7 was done, was it done looking at that process,
8 versus the ICD process?

9 MR. DICKERSON: The testing for what
10 we have in front of us was based on using the ICD
11 because that was what was available at the time
12 the testing was done. Yes, the ICD-9.

13 MS. MUNTHALI: So perhaps I can help
14 here. So NQF, our policy is that we wanted by
15 October of last year, when ICD-10s were
16 implemented, for developers to at least show a
17 crosswalk between ICD-9 and ICD-10, recognizing
18 that it would take quite a few years for uptake
19 and for developers to have access to test beds to
20 do that.

21 So there is some lag time in between,
22 as long as in your measure submission, which I

1 think you've provided a crosswalk between ICD-9
2 and ICD-10, and perhaps where those, there is a
3 line between those codes that would meet our
4 requirements.

5 MEMBER BIALEK: I think that the norm
6 though, is that codes are added. And I could see
7 that argument. In this instance, a code was
8 removed, which potentially adds a substantial
9 burden to the facility.

10 CHAIR McINERNEY: But if the patient
11 gets an influenza immunization, then that would
12 be a CPT-4 code, right? And that would be
13 feasible to collect that.

14 MEMBER HILL: Where it's embedded --

15 MS. MUNTHALI: I'm sorry, can't find
16 the mic.

17 MEMBER HILL: Three, oh, yes. So the
18 question is where is that CPT code embedded. And
19 if they've been querying a different level of
20 code in the hospital because of the DRG
21 influences, you roll up the ICD-10s to get the
22 DRG. Then that would be problematic.

1 MEMBER HARRIS: But the CPT codes for
2 this are two, four, six -- there are six
3 different administration codes for vaccines, and
4 it's not specific for influenza. So that's not
5 in 04604614714727374.

6 MEMBER TEUTSCH: There must be a code
7 somewhere for the specific drug, or in this case,
8 biologic, that's being administered, as opposed
9 to -- because the CPT will capture the
10 administration, that's the procedure, right? But
11 not necessarily the drug.

12 And there are, I don't recall how all
13 those drugs are coded, but there should be a code
14 for --

15 MEMBER HILL: There are HCPCS codes
16 for the drugs.

17 MEMBER TEUTSCH: Drugs, yes. So it
18 should be somewhere.

19 MEMBER HILL: Yes, CPT codes for the
20 administration and then the associated diagnosis.
21 And you go to figure out whether you're going to
22 get paid, you go to the national, look at the

1 national or local determination codes to see how
2 many of those you have to have to get --

3 MEMBER SPANGLER: The other point,
4 Arjun made this point earlier about how many
5 people are actually going to use the CPT code in
6 the hospital. Because if it's part of the DRG,
7 you know, I mean, it just. Why are they going to
8 do it, yes.

9 MR. DICKERSON: Our understanding is
10 the CPT code is not used in the hospital.

11 MEMBER VENKATESH: I guess I wouldn't
12 stress too much about the coding, and the reason
13 is this: the purpose of the code for the flu
14 vaccine is to identify cases for the numerator,
15 right, not the denominator. The numerator for
16 this measure is already sky-high.

17 So, even in the current world of
18 however this data's captured, and it's actually
19 captured by chart abstraction. Mostly people are
20 looking through the chart to see was this patient
21 eligible for a flu shot and was it given or not.
22 Performance is already well north of 95 percent.

1 And so whether or not you capture a
2 few that are coded in procedures here and there
3 actually doesn't matter. I'd worry a lot about
4 this if performance was low and we said, Oh,
5 well, this was only happening 30 percent of the
6 time, and it's probably because it's not being
7 captured in claims. But they are capturing.
8 They're finding the numerator right now.

9 MEMBER SPANGLER: It's obviously
10 feasible because of the percentages.

11 MEMBER TEUTSCH: I mean, it's
12 feasible, I mean, we know you can get it from
13 charts. But the problem is it's labor-intensive
14 to get it from charts. And you know, if you
15 could get it from codes, then you say, Well,
16 that's pretty simple to do. But to me, this is
17 an enormous burden for relatively modest gain.

18 And so it depends what we mean by
19 feasibility. Is it possible? Sure it's
20 possible, but I think this is a practicality
21 question, isn't it? As much as anything. And
22 somehow I think our job is to assess the

1 tradeoffs.

2 MEMBER HARRIS: So that was just my
3 point when I asked about the EHR component,
4 because I think it's just a lot of work that
5 would go into capturing this information. And
6 specifically, with the translation of the coding,
7 it would just, it's going to make it even more
8 onerous or laborious.

9 MS. MUNTHALI: Amy.

10 MEMBER MINNICH: I'll just come out of
11 my shell. From a clinical and formatic
12 standpoint, there is technology that could help
13 with some of that unstructured data, such as
14 natural language processing. And so there are
15 other efforts that you can put in place to try to
16 get that data.

17 MEMBER SPANGLER: I think what Steve's
18 asking is the definition there of could it be
19 captured without undue burden. Because that's
20 what the definition is there, feasibility. And I
21 think that's what you're asking, is it an undue
22 burden or not.

1 MS. MUNTHALI: Matt.

2 MEMBER SALIVE: Is this issue only
3 applied to this one of the nine flu measures?

4 MS. MUNTHALI: This is a --.

5 MEMBER SALIVE: Can we start over?

6 MS. MUNTHALI: This is a great
7 question.

8 MS. MUNTHALI: Yes, it is, it is. Now
9 this is the first time you guys brought it up as
10 a significant concern. But perhaps you have some
11 data you can share. Bob, I don't know what
12 you've learned from implementation of this.
13 Well, you've heard from end users on the
14 implementation of this measure to share.

15 MR. DICKERSON: In terms of
16 abstraction burden -- or, okay, just wanted to
17 make sure I was clear. Actually, most of the
18 chart-abstracted versions of measures, this one
19 probably has the least amount of burden
20 associated with data collection, because of the
21 way that hospitals are collecting the data in
22 screenings forms when patients arrive to the

1 facility.

2 They'll actually have screenings where
3 a nurse has this built in a part of their
4 admission process, and they check, has the
5 patient received it before, are they eligible for
6 it, refuse it, have a contraindication. So a lot
7 of that information is captured up front in a
8 screening form.

9 And then for the folks that are doing
10 the abstraction, they can go to that information.
11 And if one of those options is not checked, it
12 really narrows down what they need to look for.

13 MS. MUNTHALI: Okay, I think we'll
14 move to a vote on feasibility for Measure 1659.
15 One is high, two is moderate, three is low, and
16 four is insufficient.

17 (Voting.)

18 Okay, on feasibility, two voted high,
19 eight moderate and four low. And so this measure
20 passes on feasibility, and we'll move to
21 usability and use.

22 MEMBER SPANGLER: So pretty high

1 usability and use. It's already being used in
2 several publicly reported programs already.

3 MS. MUNTHALI: Barry's giving the
4 thumbs up. Any other comments, questions? Okay,
5 we'll proceed with a vote. For 1659, one high,
6 two moderate, three low, and four insufficient.

7 (Voting.)

8 Steve?

9 MEMBER TEUTSCH: Again, it gets back
10 to the definition here. Is it going to be used
11 for accountability and performance improvement?
12 If we think that improvement can't go anywhere,
13 then isn't that low? I mean, usability, yes,
14 it's practical and people are using it.

15 But at what point do you say that it's
16 not much use for performance improvement?

17 What do we do to repeal the vote?
18 Take it to the legislature?

19 MEMBER VENKATESH: I think what people
20 are struggling with, I'm struggling with this as
21 well, is like when you look at usability and use,
22 is it kind of a retrospective assessment? So

1 highly successful are going to have had a lot of
2 use and improvement, right. Like part of this
3 is, was there improvement since you used the
4 measure.

5 And there has been since this got
6 publicly reported. If you look at that data, the
7 mean went up like 15 percent, 20 percent. Or is
8 this a prospective guess from this committee?
9 Committee on like what's going to happen in the
10 future. Because then agree, I highly doubt that
11 the performance is going to improve from where
12 we're at right now. I don't know how you -- I'm
13 sure this has come up.

14 There have been plenty of measures
15 that have been near topped out that committees
16 have struggled with this issue before. And so
17 I'm just thinking like we should at least try to
18 consistent within this group. Because we'll see
19 more measures that are topped out too.

20 MS. MUNTHALI: Yes, and this
21 committee, I can tell you, for many of the other
22 topical areas, like surgery and safety and

1 cardiovascular, well, we've had measures in our
2 portfolio for quite some time. A lot of them, of
3 the standing committees, have been opting for
4 reserve status. Because they've had some sort of
5 trend data over time.

6 They can see that you know, there have
7 been improvements, but there's really not that
8 much room for additional improvement. So you are
9 starting that discussion as part of your
10 committee. And I can't remember any of our
11 measures in reserve status.

12 So I can see maybe three years from
13 now, quite a few of them may be in reserve
14 status. So this is why we offered it as a
15 recommendation for you guys, if that's the option
16 you wanted to take. Matt and Barry-Lewis.

17 MEMBER STIEFEL: Can we vote for a
18 reserve status even if it passed all of the other
19 criteria?

20 MS. MUNTHALI: It has to pass all the
21 other criteria for you to vote on reserve status.

22 MEMBER STIEFEL: Oh, okay.

1 MS. MUNTHALI: Because we're saying
2 it's still a sound measure, it's just one that,
3 you know, we may not be monitoring as frequently
4 as a measure that is endorsed without reserve
5 status.

6 MEMBER HARRIS: Yes, so that was
7 actually what I had turned the chin up was for,
8 how can we place it, you know? On the agenda as
9 a reserve, you know, for the next cycle now, so
10 that we don't get to next time and revisit this
11 whole.

12 MS. MUNTHALI: So what would happen is
13 on performance gap, where we have consensus not
14 reached, it was seven moderate, seven low, yes,
15 seven low. It's consensus not reached. You may
16 want to think about it, receive the comments from
17 NQF members and the public during the post-
18 comment call.

19 That may sway you to say, You know
20 what, we really think this is a sound measure but
21 there is very little room for improvement. We
22 want to monitor it, but not as frequently as we

1 do others. So there's still an option. But it
2 has to pass all of the other criterion.

3 Okay, I think Matt and then Bob.

4 MEMBER STIEFEL: How do we do that?

5 MS. MUNTHALI: How do you vote on it?

6 MEMBER STIEFEL: I mean, does it take
7 a motion to put it in reserves?

8 MS. MUNTHALI: Yes, but we have to
9 finish. We've done usability and use, so we can
10 go back to performance gap if you'd like, now.

11 Or if this conversation, since we
12 talked about performance gap, has swayed you to
13 insufficient to low, then we would just decide as
14 a committee to say, Yes, we would like to
15 recommend this for reserve status or no. If you
16 vote no, the measure is not recommended. So.

17 MEMBER SPANGLER: So how many have to
18 vote low or insufficient to get to that point?

19 MS. MUNTHALI: So you have to have 61
20 percent.

21 MEMBER SPANGLER: Oh, so it's the same
22 as for the passing things you have to have that.

1 MS. MUNTHALI: Exactly.

2 MEMBER SPANGLER: So the negative it's
3 a, wow. Okay.

4 MS. MUNTHALI: So that's something you
5 should consider.

6 MEMBER SPANGLER: But do we need a
7 motion to go back and revisit that, or are we
8 going to do that?

9 MS. MUNTHALI: Do you want to make a
10 motion? Somebody from the committee should make
11 a motion.

12 MEMBER SPANGLER: We need to
13 reconsider the previous vote, is what your
14 Robert's rules would say.

15 MS. MUNTHALI: Okay.

16 MEMBER HARRIS: We would move to
17 reconsider --

18 CHAIR McINERNEY: Performance gap.

19 MEMBER HARRIS: Performance gap
20 motion.

21 MS. MUNTHALI: Okay, so yes, we'll
22 finish use and usability. But wanted to also

1 remind you that you did ask for some specific
2 performance gap information on Native American
3 populations and other sub-populations.

4 Do you think that's significant enough
5 that would say, Well, you know we probably should
6 endorse this measure without condition of reserve
7 status. So I just, if that's the case, if you
8 think that's going to be significant enough, then
9 let's wait until the post-comment call and see
10 what Bob and his team can produce for us in the
11 way of those data.

12 Then we proceed. But if you think
13 that's not significant enough to sway you to vote
14 for reserve status, then we can continue with
15 that motion.

16 CHAIR McINERNY: So first of all,
17 feasibility looks like it passes. What's the
18 percentage?

19 MS. MUNTHALI: Usability.

20 CHAIR McINERNY: Oh, usability looks
21 like.

22 MS. MUNTHALI: It's, we're good on

1 usability and use.

2 CHAIR McINERNY: Yes.

3 MS. MUNTHALI: But then Steve was
4 concerned about where we factor in opportunities
5 for improvement.

6 CHAIR McINERNY: Yes, so the question
7 before the committee is do we want to re-vote now
8 on the performance gap? Yes.

9 MS. MUNTHALI: And before we do that,
10 Bob, you had something to say. Sorry.

11 MR. DICKERSON: Yes. So one of the
12 things when we're looking at performance of the
13 measure, and yes, in terms of percent of patients
14 that are being screened to receive the
15 vaccination, it is in the mid-90s.

16 Also of note is when we look at this
17 from a hospital perspective, the percent of
18 hospitals that are scoring less than 90 percent
19 of their patients being vaccinated is in the
20 range of 20-25 percent. And the reason it's 20-
21 25 percent is that analysis was done based on the
22 reporting quarter.

1 So for fourth quarter of 2014, it was
2 25 percent, and for first quarter of 2015 it was,
3 let's see, actually about 16 percent rather.

4 And I think that's one of those areas
5 where, regardless of what the decision is of this
6 committee, I think it merits some additional
7 analysis to try to identify why do we see that
8 large a percent of hospitals scoring below 90
9 percent but we're seeing 94 percent roughly of
10 all patients immunized and screened.

11 And then, as it was pointed out also,
12 the disparities, the Native American group and
13 others.

14 CHAIR MCINERNEY: All right, so are we
15 ready to re-vote on performance gap?

16 MS. MUNTHALI: And just to clarify, 61
17 percent of you would have to vote low, because
18 you're saying there's no opportunity here, very
19 little opportunity for improvement. Not
20 insufficient but low.

21 (Voting.)

22 So it is 64 percent. So we can take

1 a vote on whether or not you would -- so let me
2 read this out for the record. Sheila can bring
3 up the votes.

4 So zero voted high, five voted
5 moderate and nine voted low for performance gap.
6 And so the committee would like to consider
7 whether or not this measure can be placed in
8 endorsement with reserve status.

9 And so Sheila, if you can bring up, I
10 think there's a slide for that, if there's not.
11 I can't read the fine print. Maybe you should
12 read it out. Sorry.

13 MS. CRAWFORD: Endorsement
14 maintenance, potential for reserve status. If a
15 measure is under endorsement maintenance review
16 and did not meet importance to measure and report
17 only due to lack of performance gap 1d, does it
18 meet criteria to consider for potential reserve
19 status?

20 High performance is likely due to
21 actual improvement versus issue with measure
22 construction. Strong direct evidence proximal to

1 desired outcome, high ratings for reliability and
2 validity, possibly moderate, demonstrated use,
3 demonstrated improvement. One yes, two no.

4 MS. MUNTHALI: Thank you.

5 MEMBER SPANGLER: Do we have to, this
6 supplements voting for endorsement by itself. We
7 don't have to vote for endorsement and then do
8 reserve.

9 MS. MUNTHALI: Yes. You just do this.

10 MEMBER SPANGLER: Just do this, got
11 it.

12 MS. MUNTHALI: So if you say no,
13 majority 61 percent and over say no, this measure
14 would not be recommended for endorsement.
15 Because remember, it received a low vote on
16 performance gap, which is a must-pass criterion.
17 So, again, just wanted to put that there. So if
18 you wanted for reserve status, you should say
19 yes. If not, say no.

20 (Voting.)

21 So one more vote. It's unanimous, 14
22 voted yes for endorsement with reserve status.

1 So it retains its endorsement, it's NQF endorsed.
2 And as we mentioned before, we'll be looking at
3 it periodically.

4 CHAIR McINERNY: All right.
5 Congratulations, we did something relatively new.
6 And more importantly, we're done with flu.

7 (Applause.)

8 MS. MUNTHALI: Okay, we're going to
9 call up our colleagues from PCPI Foundation for
10 Hep C measures, and we're going to go through
11 this we hope rather quickly.

12 MS. OGUNGBEMI: Hello, may I have your
13 attention please. I would like to ask if you all
14 would still like to go to dinner tonight. It
15 would be at P.J. Clarke's, which is like a burger
16 and seafood restaurant about a block away.

17 Our reservation is for 6:15, so if I
18 could get a head count. We'll be done. We have
19 to be done. Yes. I could try and change the
20 reservation, but we can see.

21 CHAIR McINERNY: By the way, P.J.
22 Clarke's is a great restaurant. Thank you for

1 picking that.

2 MS. OGUNGBEMI: You're welcome. Now
3 the reservation is at Georgia Brown's because
4 P.J. Clarke's does not have any -- I'm not sure
5 what happened. They don't have any tables.

6 MS. MUNTHALI: Georgia Brown's is
7 good.

8 CHAIR McINERNY: Yes.

9 MS. MUNTHALI: So we'll make a
10 reservation for about ten, maybe. Staff is
11 going, and we'll make it for ten. Whomever
12 shows, shows.

13 CHAIR McINERNY: 6:15, Georgia
14 Brown's. Where is it?

15 MS. OGUNGBEMI: We'll give you the
16 address.

17 CHAIR McINERNY: Okay, thank you.

18 MS. MUNTHALI: Okay. So the next set
19 of measures, the three measures that assess an
20 aspect of Hepatitis C screening, Measure 3059:
21 One-Time Screening for Hepatitis C Virus for
22 Patients at Risk. And the other is an Annual

1 Hepatitis C Virus Screening for Patients who are
2 Active Injection Drug Users. And the third one
3 is Appropriate Screening Follow-up for Patients
4 Identified with Hepatitis C Virus Infection. So,
5 we asked PCPI Foundation to go through these
6 rather quickly because they flew in from Chicago.
7 They can't come in tomorrow. I'm going to try to
8 get through this very quickly but they're going
9 to summarize the three measures together and
10 we're trying to find other efficiencies as well.

11 Thanks.

12 MS. BOSTROM: Thank you. My name is
13 Beth Bostrom of the PCPI Foundation and I will
14 kick it off to our expert Dr. John Ward.

15 DR. WARD: Good afternoon, everyone.
16 I'm Dr. John Ward and I'm the Director of the
17 Division of Viral Hepatitis. At CDC we developed
18 these measures in collaboration with PCPI. It's
19 very appropriate that we talk about all three of
20 them together because they're striking to the
21 heart of a key prevention priority at CDC and the
22 USPSTF and that is to increase testing and

1 knowledge of HCV infection among persons at risk
2 and link them effectively to care and treatment
3 at a time where we now have safe and highly
4 effective cures for Hepatitis C.

5 A quick survey that was in your
6 materials that you read prior to this meeting,
7 the burden of Hepatitis C is large, about three
8 and a half million people are living with
9 Hepatitis C. The knowledge of infection is low,
10 only about half the people based on NHANES report
11 knowledge of their infection before they were
12 tested based on that survey. Mortality is
13 increasing. It's now the largest cause of
14 infectious disease related mortality among
15 conditions considered to be nationally notifiable
16 to CDC. And, in fact, you put all the other 60
17 notifiable conditions together and the number of
18 deaths from Hepatitis C supersedes all of those
19 combined. And those stats are among primarily
20 among this birth cohort that has the high
21 prevalence with an average age of death at 59.
22 And there's large disparities within that cohort,

1 particularly, high prevalence and mortality among
2 black Americans and among American Indians.

3 The other area that we want to address
4 is an epidemic of HCV transmission. There's been
5 about 150 percent increase in incidents between
6 2010 and 2014. This is among persons who inject
7 drugs and we have a none disparity here where
8 it's almost predominantly white in suburban and
9 rural areas of the country equally male and
10 female populations that have not experienced this
11 type of transmission. And this is very much
12 related to the opioid epidemic and then the
13 injection of those opioids leading to Hepatitis
14 C transmission. And we're now seeing even some
15 secondary transmission from mother to child.

16 The benefits of testing. There are
17 some benefits of knowledge of your status and
18 also in changes in care and behavior such as
19 changing your alcohol use, which can lower your
20 risk of liver disease but the linkage into
21 treatment is very, very important we now have
22 drugs with one to several pills a day for eight

1 to twelve weeks, 90 percent cure in clinical
2 trials and the data show very little drop off in
3 that success rate in routine clinical practice.

4 But people who are cured of their
5 Hepatitis C they have large reductions in liver
6 cancer rates, all-cause mortality and progression
7 of their cirrhosis so there's some clear
8 benefits.

9 Since we prepared this packet for your
10 consideration we have continued to publish data
11 to show how the implementation of these testing
12 policies and linkage to care can increase the
13 number of people being successfully linked to
14 care among low income African Americans in
15 Philadelphia, Hispanics being cared for and
16 safety net hospital in San Antonio, Texas, and
17 among the American Indian populations in the
18 Indian Health Service and in the Cherokee Nation.

19 We have a large gap in testing and
20 linkage to care that we hope that we can work
21 together with NQF to address and measure and
22 improve performance.

1 Thank you.

2 MS. MUNTHALI: Thank you, Arjun.

3 Amelia, I don't know if you've joined us. I
4 think it's just Arjun.

5 MEMBER VENKATESH: I guess one question
6 because I reviewed a bunch of the eMeasures.
7 This is an eMeasure for full endorsement or for
8 the trial standard use?

9 MS. MUNTHALI: Trial use.

10 MEMBER VENKATESH: Trial use. Okay.

11 So, this measure is a great
12 description obviously a very important topic. It
13 is essentially a high-risk Cap C screening
14 measure and I think in my review of this as a
15 trial use measure the idea here is that we
16 evaluate whether or not there's enough here to
17 suggest the problem is important, that there is
18 some practice that we should measure this and
19 that they should kind of fully develop the
20 eMeasure and then do some of the subsequent
21 validity and reliability testing.

22 The screening types of analysis that

1 were done about this in terms of measuring
2 properties to me all looks good in terms of being
3 able to capture a lot of this data
4 electronically. I think that all makes sense.
5 The only concern I had about this measure that I
6 put in my original review and I don't know how
7 and where to put it in this discussion is not
8 actually about the electronic specification or
9 about the measure. It's about the evidence and
10 the performance gap.

11 On the evidence side there is
12 primarily the reason to rate this probably
13 moderate is that there is a lot of clinical
14 practice guidelines and consensus things
15 including from the CDC that suggest that this is
16 important and that high risk people should be
17 screened. And I can live with that and you can
18 rate that as high as I think moderate based on
19 what they've done.

20 The issue becomes on the performance
21 gap there's two studies cited about inadequate
22 screening. And I did not do the extra, you know,

1 literature review to find other papers. But the
2 two that are cited come from NHANES data between
3 2001 and 2008 is one study that suggests that
4 people don't know their Hep C status. That's an
5 important gap and problem that's different than
6 this measure. This measure is not about patient
7 knowledge. It's about patient screening so the
8 second study they cite is also from NHANES data
9 2006 to 2008. In that data of the 12 percent of
10 people that did not know they had Hepatitis C, I
11 think five and a half percent tested positive on
12 the blood sample. So that to me would be good
13 data except I'm a little afraid that it's almost
14 a decade old looking at whether there's
15 inadequate screening. And so I am left with I
16 think as I looked at the evidence and performance
17 gap on this measure something I think is really
18 important, something where there's strong
19 consensus about the importance of screening but I
20 don't necessarily know that there's a gap that
21 suggests that there is -- I don't know that there
22 is evidence that shows that there's a screening

1 gap right now. And I just don't know where that
2 fits into a trial use measure. Because it's not
3 about the measure and the eSpecifications. It's
4 just about the evidence of a performance gap
5 right now.

6 MS. BOSTROM: And I think if we could
7 speak to Dr. Venkatesh's point just a little bit.
8 I believe Dr. Ward touched on this a bit in his
9 introduction but we do have some newer data from
10 Indian Health Services that includes 1.9 million
11 members, that includes 566 Federally recognized
12 tribes, through a wide network of facilities that
13 did implement a performance measure that really
14 looked at cohort screening, one time cohort
15 screening for those at risk and what they did
16 find was that from 2012 to 2015 the baseline rate
17 increased from 7.9 percent to 32.5 percent. So,
18 I think that the newer data definitely supports
19 that. And the study also showed further
20 variation. More women received screening than
21 men and that there were also some geographic
22 variation. Regions varied from 31.2 percent to

1 41.2 percent and there was even wider variation
2 amongst facilities measuring from 1.9 percent to
3 41.2 percent. So, we thought that that could
4 further highlight, you know, some more recent
5 efforts about screening for the at risk
6 population.

7 MS. MUNTHALI: Jacki.

8 MEMBER MOLINE: I just have a quick
9 question. If someone had been screened five
10 years ago it looks like it's looking for current
11 screening as opposed to past screening. So, can
12 you just clarify if the numerator or denominator
13 because if someone's in the baby boomer cohort
14 and he is in the group that's supposed to be
15 screened just solely based on birth date but they
16 were screened five, ten years ago are they
17 included, excluded?

18 DR. WARD: It should be excluded.

19 MS. APURA: So, actually our numerator
20 in the specification says that all HCV laboratory
21 test, HCV antibody test, HCV RNA test, HCV Riba
22 Test all those happen before the measurement

1 period of those included in the numerator and
2 also tests that are included during the
3 measurement period too.

4 MS. MUNTHALI: Steve.

5 MEMBER TEUTSCH: Sean, you and your
6 colleagues have done a great job in bringing this
7 to everybody's attention. But sort of the
8 elephant in the room, I'm not sure it's eligible
9 for us to think about and that's the cost.

10 As these are costly drugs, even though
11 I know there's cost-effectiveness studies out
12 there that show that it's been cost-effective but
13 it's really not affordable for many, many, many
14 and particularly Medicaid, public health clinics.
15 I know in LA County they said if they followed
16 this it would cost more than their total annual
17 budget. And there are other strategies as you
18 know that we could use so that you don't have to
19 take everybody all at once. People can get
20 reinfected. Even if they are treated if they
21 keep up some of the high-risk behaviors or you
22 eradicate this disease. It's not necessarily

1 just a one-time cost.

2 So, I don't know and I guess it's an
3 NQF question. Are we supposed to think about
4 things like that as a trial measure to see if you
5 can get it? Does it meet specifications? I
6 think we've heard that that's all good. But I
7 truly worry about really the affordability vis-a-
8 vis the system more broadly. The Government
9 could technically march in and take over those
10 patents because they have march-in authorities
11 and they've chosen never -- not just to this but
12 they've never used those abilities. So I just
13 wonder though, you know, given that it's a real
14 public health problem you've laid out and there's
15 some really good solutions from a medical
16 perspective but we have a real mismatch with the
17 economics.

18 MS. MUNTHALI: So -- no, you definitely
19 should respond. Yes, cost is something that we
20 do consider as part of our feasibility assessment
21 of every measure that comes through regardless if
22 it's a measure that's seeking endorsement from

1 NQF or a trial use. Trial use is not
2 endorsement. We are saying, you know, these
3 measures should go out there. The developers
4 should go out and test as best that they can.
5 They have three years to come back to us. Some
6 measures may not make it and it could be because
7 of the barriers with testing or it could be some
8 of the resource barriers like cost. We don't
9 know that but I just wanted to put that
10 disclaimer on there again that this measure and
11 these other that will proceed in this group
12 they're coming forward for trial use not for NQF
13 endorsement. So, I don't know if that helps.

14 MEMBER TEUTSCH: Well, it helps me a
15 little but I believe that when they're done you
16 can show that this is feasible. I don't have
17 really much doubt that this can be done. But
18 then you're sort of you're asking the same
19 question. The question is when do you ask the
20 question as to, you know, you're sort of on the
21 slippery slope, if you will.

22 MS. MUNTHALI: You brought up

1 feasibility issues. And that we talk about
2 anytime with any measure.

3 DR. NISHIMI: It's not just the
4 technical feasibility of it. It's whether the
5 cost of doing the measure outweighs the benefits
6 too. So, it's not just, you know, we can collect
7 this data and give you a score.

8 MEMBER TEUTSCH: My guess is, it's
9 feasible and cheap to do the measure. It's not
10 the measure that's the problem it's the cost of
11 the drug.

12 DR. WARD: Let me chime in at this
13 point.

14 Within the testing and the linkage to
15 care that everybody should know their status in
16 care so that their stage of disease can be
17 evaluated. When you look at the birth cohort and
18 we've done a study and Stanford has done a study
19 about one out of every four baby boomers here
20 have Hepatitis C infection already had severe
21 fibrosis or cirrhosis. So, even in the most
22 restrictive Medicaid reimbursement criteria they

1 would qualify for treatment because it is so
2 highly cost effective and probably cost saving to
3 treat people at that severity of disease. But
4 that's one thing.

5 Two, as far most baby boomers, I'd say
6 about 90 percent of the baby boomers are
7 transmission dead enders. You know, they're not
8 engaged in risk behaviors to transmit to others.
9 They were infected decades ago and now they're
10 getting ill.

11 On the cost side, the original drugs
12 that came out in '14 were about \$86,00 to \$94,000
13 per puritive course. Through competition and
14 negotiation in just two years that's fallen to
15 about \$46,000. So, our original cost
16 effectiveness modeling on a societal level showed
17 that that was cost effective to treat people who
18 were infected. We just updated that analysis
19 with using a benchmark of about \$41,000 and
20 showing that it's cost neutral now because of the
21 benefit of the reduced cost. So, I think we have
22 to look at the true cost as a moving target. I

1 mean, I think this is an evolutionary process and
2 it's heading in a positive direction in just two
3 years. But we need to be mindful of cost, but
4 again I think what we're measuring is the testing
5 and getting people into care so that they can be
6 staged and then see what is their priority for
7 treatment. As you were saying, you may not treat
8 everybody immediately. You may not. But they
9 all need to be in care and staged to make that
10 decision. That's the way I look at the three
11 measures collectively.

12 On the injection drug use, quickly on
13 the injection drug use side they do have risk for
14 ongoing transmission and I think there's a
15 different cost effectiveness that we have to put
16 into play there and we're still trying to figure
17 that out.

18 And then lastly it's very interesting
19 you should bring that up, Steve, because the
20 other reason I'm up here is because HHS has
21 convened a two-day meeting to look at how they
22 can improve the affordability of HCV treatment.

1 So, there's different options for that.

2 Thank you.

3 MS. MUNTHALI: Other questions?

4 Concerns?

5 Okay. So, we'll vote on Performance
6 Gap, one, high, two moderate, three low and four
7 insufficient.

8 (Voting.)

9 MS. MUNTHALI: Sorry, I'm reading
10 what's on the screen.

11 So, this is a new measure. It is
12 eligible for trial use not NQF endorsement but we
13 still need to assess the evidence base. This is
14 Measure 3059.

15 Okay. Evidence, one high, two
16 moderate, three low, four insufficient.

17 (Voting.)

18 MS. MUNTHALI: So, we have 13. Ron is
19 gone for the day. So, we have four high, eight
20 moderate and one low. So, this measure passes on
21 evidence so we'll move on to Performance Gap now.

22 DR. NISHIMI: Arjun, you were the one

1 who raised the issue about Gap. Is there
2 anything you wanted to add? You've heard the
3 PCPI Foundation response with the updated
4 information.

5 MEMBER VENKATESH: I guess I would
6 still interpret it probably as -- I guess how do
7 you for these trial standard measures how do you
8 interpret a gap that's not specific to like the
9 measure focus?

10 DR. NISHIMI: Well, wasn't your Indian
11 Health Service specific to the focus of the
12 measure?

13 MS. BOSTROM: It was specific to the
14 birth cohort.

15 DR. NISHIMI: Well, I mean it's really
16 up to the committee whether you feel that by
17 inference you can feel comfortable voting
18 moderate that there is a gap. It is by
19 inference.

20 (Voting.)

21 MS. MUNTHALI: We're missing one vote.

22 (Voting.)

1 MS. MUNTHALI: Okay. Three high, seven
2 moderate and three low for performance gap for
3 Measure 3059. So, it passes and we move on.

4 DR. NISHIMI: The next section is on
5 the Scientific Acceptability. Recall that
6 there's no testing data here because this is for
7 trial use so the Committee's decision really is
8 about whether you feel the specifications are
9 appropriate given the evidence.

10 MS. MUNTHALI: Arjun, did you have any
11 other concerns with the specs?

12 MEMBER VENKATESH: No, and on the sheet
13 it had a big red don't evaluate.

14 DR. NISHIMI: Well, the evaluation
15 really is around whether there is evidence in the
16 specs you feel match the evidence.

17 MS. MUNTHALI: Right so you're not
18 voting on reliability validity.

19 DR. NISHIMI: So, we ready to vote on
20 scientific acceptability? We're voting now on
21 the scientific acceptability because we're not
22 voting on reliability per se. We're not voting

1 on validity per se.

2 (Voting.)

3 DR. NISHIMI: Oh, okay. Then this is
4 for Measure 3059. It's not for reliability.
5 It's for the scientific acceptability and I can't
6 see the number.

7 MS. MUNTHALI: So, four high, eight
8 moderate and one low so it passes. So, let's
9 move on to feasibility. And there should be some
10 discussion here. Arjun.

11 MEMBER VENKATESH: I mean what they
12 submitted in the original application suggested
13 that the preliminary feasibility looked pretty
14 good. I don't have any reason to think that you
15 couldn't get a lot of these things from the HR.
16 I guess they'll show us when we see it the next
17 time around whether or not -- the main concern
18 would be whether or not you're missing people who
19 have a history of a one-time test. So, if you
20 move around, if you capture one of the HRs the
21 data is sitting somewhere else but that seems
22 like it's outside the scope of what we're trying

1 to figure out today. And so from an overview
2 look at feasibility it seems like these data
3 elements are in EHR and I'd give it, I guess
4 moderate? High?

5 MS. MUNTHALI: Steve.

6 MEMBER TEUTSCH: Can I ask John, and
7 Colene, so feasibility is really about not just
8 the performance metric per se but sort of, you
9 know, are people going to use this and to what
10 extent to actually drive change in the
11 organizations? Can you talk a little bit about
12 how different types of organizations whether
13 they're plans, HMOs, you know, public health
14 clinics, public health hospitals are actually
15 prepared to use, you know, to do this? I know
16 there is a philosophical yes, we'd love to do it.
17 But on a practical side what are they actually
18 doing in terms of the actual, you know,
19 implementing and then the screening and then, you
20 know, the management of those people?

21 DR. WARD: So, we're tracking testing
22 using millions of records from two large

1 commercial laboratories. We've seen 60 percent
2 increase in testing since these recommendations
3 were put forth in 2012. And that's with a very
4 limited implementation budget from CDC.

5 And you saw an example from the Indian
6 Health Service of a system really finding ways to
7 implement this through provider education and
8 clinical decision tools so that you get pop-ups
9 when someone enters into the clinic, in the birth
10 cohort. So, and there's been endorsements by
11 America's Health Insurance Plans. Kaiser has put
12 in a clinical decision tool. So, I think there's
13 a lot of -- there's a variety of effort not as
14 large as frankly I would like but there's some
15 good examples of a major health system doing
16 something and, of course, the VA has been about
17 this for almost 20 years now and have 80 percent.
18 They believe they've found 80 percent now of
19 Hepatitis C veterans who use their veteran system
20 and --

21 MEMBER TEUTSCH: What about Medicaid
22 plans?

1 DR. WARD: Medicaid?

2 MEMBER TEUTSCH: Medicaid.

3 DR. WARD: Well, Medicaid we are just
4 now getting into looking at that. We have seen
5 increases even among Medicaid populations in
6 testing. You know, one of the big barriers has
7 been getting access to treatment because of the
8 budgetary issues for Medicaid programs. And
9 that's been a disincentive to test. So, that's a
10 problem.

11 Our big effort going forward, we just
12 put out money to State Health Departments to help
13 them begin to work with FQHCs which we think will
14 help us address some socioeconomic and racial and
15 I think disparities. Many of those will be on
16 Medicaid to improve testing. So, we'll find out
17 more as this moves along. But we have examples
18 of systems implementing testing and testing
19 increasing nationally if that answers your
20 question.

21 MEMBER TEUTSCH: And then they're
22 following up and treating?

1 DR. WARD: They are. We have in
2 addition to the Indian Health Services there's a
3 number of other examples of people being linked
4 to care from emergency departments, hospitals,
5 homeless clinics, etcetera. So, it does improve
6 linkage to care even in these budgetary issues.

7 MS. MUNTHALI: Any other comments?
8 Okay. We're ready to vote on feasibility for
9 3059, one high, two moderate, three low and four
10 insufficient.

11 (Voting.)

12 MS. MUNTHALI: One high vote, ten
13 moderate votes, two low and so this measure
14 passes on feasibility and we'll move on to
15 usability and use. Any new concerns to bring
16 up, Steve, your concern about cost will apply it
17 to usability and use as well. Anything else to
18 add?

19 MEMBER TEUTSCH: No, I just think from
20 this conversation clearly there's a push to make
21 it work and there's a huge barrier in terms of
22 affordability which makes it really, really

1 tough. And I know people are working on it but
2 time will tell. And I know just from my local
3 experience that --

4 DR. WARD: As a brief addendum I mean
5 the USPSTF Category B does help address some of
6 the cost issues of testing because that should be
7 not --

8 MS. MUNTHALI: Steve, your microphone,
9 sorry.

10 MEMBER TEUTSCH: Yes, but health claims
11 are supposed to provide that testing service
12 without copay.

13 DR. WARD: Correct, but they don't in
14 their decision --

15 MEMBER TEUTSCH: No, I meant in terms
16 of the patient burden.

17 DR. WARD: Correct.

18 MEMBER TEUTSCH: Not always but often
19 times that has been addressed in particularly
20 primary care settings.

21 MS. MUNTHALI: It looks like there are
22 no other concerns with regard to usability and

1 use. So, we'll start to vote. One is high, two
2 is moderate, three is low and four is
3 insufficient.

4 (Voting.)

5 MS. MUNTHALI: So, for Measure 3059,
6 usability and use, one high, eight moderate,
7 three low and one insufficient. So this measure
8 passes usability and use.

9 And the recommendation for approval in
10 the Trial Use Program. One is yes and two is no.

11 (Voting.)

12 MS. MUNTHALI: Eleven voted yes and two
13 voted no for inclusion in the Trial Use Program
14 so this measure is approved.

15 So, we'll move on to the next measure
16 also stewarded by PCPI and this is 3060. We are
17 not going to do the developer overview. We did
18 that already so just turn it over to Jason, is it
19 you?

20 MEMBER SPANGLER: I mean I'm in this
21 but I'm not initiating the --

22 MS. MUNTHALI: Okay. So, it's Arjun

1 and Betty Lewis, right?

2 MEMBER SPANGLER: I will join in the
3 discussion.

4 MS. MUNTHALI: Okay. We have to vote
5 on evidence. It's a new measure. Again, this is
6 an eMeasure that's eligible for the Trial Use
7 Program.

8 MEMBER VENKATESH: So, I think the
9 denominator is obviously slightly different in
10 this measure but otherwise it is essentially
11 constructed the same. They did the same degree
12 of pre-testing around the data elements. I don't
13 think I had anything new or different on this
14 measure from the previous one. I think that, you
15 know, largely this is going to be based on
16 guidelines to get the evidence rating, not on
17 actual evidence and the performance gap I'm
18 assuming that the additional information that
19 they brought is also true for this measure. I
20 don't know if they looked at the subset of folks
21 with active injection drug use in the Indian
22 Health Service. My guess would be is that

1 there's gaps in screening in non-IVDA patients.
2 It's also true there as well but I guess that
3 would be the only question but otherwise to me, I
4 think that this is essentially the same general
5 construct as the other measures, the only
6 difference being the denominator.

7 MS. MUNTHALI: Any other questions?

8 MEMBER HARRIS: I just had a question
9 about the survey of the low income position. Did
10 we look at any other group or was there a
11 particular reason why that was the place for the
12 survey -- did you like with, you know, the baby
13 boomer population did you actually think about
14 other groups than just that particular low income
15 group?

16 DR. WARD: So, is your question related
17 to injection drug users or related to birth
18 cohort?

19 MEMBER HARRIS: Yes. I mean, I don't
20 think that it necessarily means that they have to
21 be a low income group to be an IV drug user.

22 DR. WARD: No, that's exactly right and

1 we -- we have directed our prevention research to
2 the settings that we're serving populations that
3 were experiencing health disparities and so
4 that's why it's a little bit directed in that
5 way. But if you look at larger health systems
6 like, you know, Kaiser which is published in the
7 Mid-Atlantic region, for example, you'll see
8 similar rates to what has been shown in NHANES.

9 Relative to the injection drug use
10 population, I mean, we would like to -- I think
11 the performance gaps outside of drug treatment is
12 a little bit less well described. But, you know,
13 given the behavior we're concerned, and the
14 changes in the geography of poor transmission is
15 happening, we're concerned that there are gaps
16 there that we have yet to fully described.

17 MS. MUNTHALI: Jason.

18 MEMBER SPANGLER: That kind of answered
19 my question because it doesn't -- there's not
20 data on disparities in the population we're
21 looking at here though it sounds like
22 specifically. Do we know of disparities of those

1 who are screened who are IV drug users it sounds
2 like not yet.

3 DR. WARD: We do get data from the
4 National HIV Behavioral Surveyor, NHBS, which
5 goes out and interviews persons at risk for HIV
6 including persons who inject drugs. And there
7 are racial and ethnic differences and actually
8 with Black Americans reporting higher testing
9 rates for Hepatitis C than White Americans and
10 it's believed it's because prevention services
11 have been in Black communities and urban areas
12 longer than in White communities where they may
13 even be nonexistent, particularly now in the
14 suburban and rural areas. So, there are some
15 data to suggest that there are some performance
16 gaps.

17 MS. MUNTHALI: Okay, it looks like --
18 oh, Matt.

19 MEMBER STIEFEL: Well, the numerator is
20 different too, obviously. It goes from one time
21 to annual, which does affect our thinking about
22 the evidence and the opportunity and especially

1 the usability or feasibility cost issues would
2 seem to be dramatically amplified. So, I
3 wouldn't want just with a broad brush to say,
4 well, it's just a different denominator.

5 MS. MUNTHALI: Arjun.

6 MEMBER VENKATESH: Yes, that's a good
7 point. I should have brought that one up as
8 well. I briefly looked at the guideline and I
9 know that the cited evidence from it obviously
10 suggests, I think the words are regular screening
11 or something like that. Is the one year
12 requirement lined up with the current guideline
13 where it says annual testing and annual
14 screening, because I think that would be
15 reassuring?

16 MS. BOSTROM: Yes, the guidelines which
17 we provided, the AASLD guideline does recommend
18 annual screening for persons who inject drugs.
19 And then in the USPSTF recommendations it
20 recommends periodic screening for at risk
21 populations and it says the population which is
22 at greatest risk is persons who inject drugs.

1 So, during the development of the measure the
2 work group felt that periodic would be a feasible
3 way to align with annual. So, it is explicit in
4 the evidence attachment.

5 MS. MUNTHALI: Okay, great. I think we
6 can vote. We still have a quorum. I think it's
7 11. Two people stepped out.

8 So, for performance gaps. We haven't
9 voted on evidence, sorry, again. One high, two
10 moderate, three low and four insufficient.

11 (Voting.)

12 MS. MUNTHALI: Okay. So, eight voted
13 moderate, two voted low and one voted
14 insufficient. This measure passes on evidence.
15 And now we'll move to performance gaps. Any
16 additional comments? We started talking about
17 gap.

18 MEMBER VENKATESH: I guess I just ask
19 the question, you guys had a lot of gap data for
20 a variety of populations on the last measures
21 there. Is there similar stuff you know about
22 this population or was it from the HIV survey the

1 primary data point?

2 DR. WARD: We have done demonstration
3 projects in about 10 injection drug use settings
4 and there was a wide variety in their ability to
5 successfully implement testing and wide
6 variations in linkage to care. I can't describe
7 as of right today what's all the reasons for
8 that. But we do have some clinic data to show
9 that there are differences across clinical
10 settings.

11 Some of that data was just recently
12 published in Public Health Reports in July and
13 I'm happy to make those data available with PCPI.

14 MS. MUNTHALI: Anything else? Okay,
15 let's vote on gap. One high, two moderate, three
16 low, four insufficient. And we're looking for 12
17 votes. Measure 3060.

18 (Voting.)

19 MS. MUNTHALI: So, two voted high,
20 eight voted moderate and two voted insufficient
21 so we move on to reliability, but testing,
22 essentially, or ---

1 DR. NISHIMI: This is a specification.
2 So, this is the same issue. It's trial use. So,
3 there's no testing data and the question to the
4 committee is whether you feel the specifications
5 represent the evidence well enough to go forward
6 with the trial use.

7 (Voting.)

8 MS. MUNTHALI: Steve.

9 MEMBER TEUTSCH: I have a question.
10 How accurate or how reliable is identification of
11 IDUs from the records that we're talking about
12 here for the denominator?

13 MS. BOSTROM: Sure. I think I'll have
14 my colleague Diedra Gray can speak to the
15 reliability of the denominator. Oh, for -- well,
16 we don't have any testing data available. I
17 think we can speak to -- I think that might jump
18 into feasibility of it.

19 MEMBER TEUTSCH: Sort of completeness
20 and, you know, accuracy.

21 MS. GRAY: Yes, so we did complete
22 feasibility testing for this measure and all of

1 the required data elements were able to be
2 captured in two different systems the feasibility
3 testing was performed in and there were no issues
4 with capturing the data. Am I answering your
5 question?

6 MEMBER TEUTSCH: No, because I think
7 it's really the sensitivity of the record for --
8 I would think specificity is probably pretty
9 high. You don't catch a lot of people saying
10 they're drug users who aren't. But I would
11 imagine that there are a lot of drug users who
12 you don't capture very easily. That's what I was
13 thinking about how good is the denominator here?

14 MS. GRAY: So, I think I understand
15 your question. So, like I said, all of the
16 required data elements were able to be captured.
17 The fact that you're focusing on the sensitivity
18 of it and the differences in the medical records
19 makes me think that perhaps it might be helpful
20 to describe that there are different
21 organizations and different vendors are able to
22 create organizations specific and vendor specific

1 codes that are able to be mapped to the required
2 data --- I'm sorry, to the standards that we use
3 to specify the measure. So, in the case where
4 someone wouldn't have been using the actual value
5 sets that are required for reporting the measure
6 they would be able to map to the required value
7 sets even if they have an organization specific
8 code or if they have a vendor specific code
9 that's different.

10 Additionally, even though it's not
11 applicable in this case, information and data can
12 also be captured through free text in the EMR.

13 MEMBER TEUTSCH: What I'm really asking
14 is, I'm sure that it can be coded and all that
15 sort of stuff. The question is, how well is it
16 recorded so that you actually have a true
17 denominator?

18 MS. GRAY: Right. And so since we
19 haven't performed the actual testing we wouldn't
20 be able to answer that until after it's approved
21 for trials ---

22 MEMBER TEUTSCH: Right. No, I get you

1 got the Hep C issues but in general, I mean it's
2 a problem for IDUs I would think.

3 DR. WARD: I think you're right about
4 the sensitivity specificity. I think that's one
5 of the reasons we went to a demographic-based
6 recommendation for the birth cohort in addition
7 to its prevalence and other reasons. But I think
8 that's -- and we've done studies to show that
9 there's -- you miss a lot of persons who have
10 this history because of the provider practices
11 and desire and willingness to, you know, to
12 explore that kind of history and the patient to
13 divulge that kind of history.

14 So, it's a problem but I think at
15 least for this measure, you know, we can at least
16 track it for those that do have that history
17 while we're seeking to improve that physician
18 practice on our side of the issue here.

19 MS. MUNTHALI: Arjun.

20 MEMBER VENKATESH: Yes, I guess one is
21 sort of related to that, would be more guidance
22 as you put this into trial use and that is that

1 we have a very active screening and referral
2 program in our emergency department for opioid
3 overdose and so similarly I think since you're
4 screening, you're trying to capture all the IV
5 drug abuse, if you construct the measure to only
6 capture that in the HR from a social history
7 where that's captured you'll probably miss some
8 of these. If you test this eventually to any
9 site that you've got any data available outside
10 of just the single practice notes I think it
11 would be worthwhile and valuable information for
12 us when we see this next time if you also screen
13 for recent emergency department visit,
14 hospitalization and all of their healthcare
15 resource use associated with overdose, treatment,
16 referral, things like that.

17 And then the other question I had that
18 I think you're going to have to figure out on the
19 specifications when you bring this back is what
20 counts as the history of IV, active IV drug use
21 because you're going to end up with in a one-year
22 measure it's going to get a little tricky when

1 you've got somebody who was an active IV drug
2 user also went to -- got screened at the end of
3 last year, went to a detox program, came back out
4 and so I think that that is probably going to be
5 a big piece of the specifications to make sure
6 there is no unintended consequences in screening.

7 MS. MUNTHALI: Okay. So, I think we're
8 ready for a vote on 2b. Specifications.
9 Consistent with evidence this is for eMeasure for
10 approval for trial use. One is high, two is
11 moderate, three is low and four is insufficient.

12 (Voting.)

13 MS. MUNTHALI: So, zero voted high and
14 10 voted moderate, three low so it passes,
15 specifications.

16 And so we'll move to feasibility for
17 Measure 3060.

18 MS. MUNTHALI: Arjun? Barry-Lewis?
19 Jason?

20 MEMBER VENKATESH: I guess again, I
21 think I would say that I do think at the data
22 element level these are feasible. These are

1 things are captured in electronic health records.
2 I think we'll have to see what the data looks
3 like to actually assess how often things like a
4 social history are being captured well and that
5 that data is present across a wide variety of
6 ages.

7 MEMBER HARRIS: I would concur that,
8 you know, it's something that definitely could be
9 captured.

10 MS. MUNTHALI: It looks like we're
11 ready for a vote on feasibility. One high, two
12 moderate, three low, four insufficient.

13 (Voting.)

14 MS. MUNTHALI: We're missing one vote
15 and we got it. Zero high, 11 moderate and two
16 low. So, for Measure 3060 it passes on
17 feasibility.

18 And we'll move on to usability and
19 use. Any discussion from Jason, Barry-Lewis,
20 Arjun?

21 MEMBER VENKATESH: Nothing new. I
22 mean, this is a tough one. It's hard to

1 interpret this when it's for trial use.

2 MS. MUNTHALI: Yes.

3 MEMBER VENKATESH: Because I feel like
4 I should just say yes.

5 MS. MUNTHALI: Okay. So, one is high,
6 two is moderate, three is low and four is
7 insufficient.

8 (Voting.)

9 MS. MUNTHALI: So, zero voted high,
10 eleven voted moderate and two low. So, this
11 measure passes on usability and use.

12 And so for approval for trial use one
13 yes, and two no.

14 So, eleven yes and two no, so Measure
15 3060 is recommended for approval for trial use.

16 So, we'll move on to the last measure
17 for today -- we want to get a pulse check from
18 you guys. Do you guys want to stop now and our
19 developers call in from Chicago tomorrow or do
20 you feel like we can push through this last
21 measure?

22 CHAIR MCINERNY: Push through.

1 MEMBER MOLINE: I think the value of
2 having them there overwhelms our sense of getting
3 out of our seats.

4 MS. MUNTHALI: Thank you, guys.

5 So, evidence really quickly. This is
6 Measure 3061 and this is for those for follow up
7 for patients identified with Hep C. Appropriate
8 screening. So, I think we have with the
9 exception of Arjun, Amy who is helping Jason and
10 Barry-Lewis out with discussing this measure, so
11 evidence.

12 MEMBER MINNICH: No pressure on the
13 girl that gives the last one. Fortunately, I
14 think it pretty much dovetails with the last two
15 that were presented. The evidence is strong,
16 although a bit dated to 2013 because of the new
17 information that's coming forward. There were 30
18 observational studies that were reported and so I
19 felt the evidence was strong.

20 MS. MUNTHALI: Any objections to that?
21 Okay. I think we can move to a vote. One high,
22 two moderate, three low and four insufficient.

1 (Voting.)

2 MS. MUNTHALI: Michael, I'm not sure if
3 you submitted your vote. If you did can you
4 submit it one last time?

5 MEMBER BAER: Did you get it?

6 MS. MUNTHALI: Would you mind sending
7 it verbally, I hope you don't mind that.

8 MEMBER BAER: Moderate.

9 MS. MUNTHALI: Okay. I got it.

10 MEMBER BAER: Yes, I sent it twice.

11 MS. MUNTHALI: We just saw it, thank
12 you.

13 MEMBER BAER: Okay. Thanks.

14 MS. MUNTHALI: Thank you.

15 Seven high, four moderate and two low
16 so we'll move to performance gaps. Amy?

17 MEMBER MINNICH: So, because it is a
18 new measure the developer just provided data from
19 the literature. There were two studies reported
20 that showed an obvious gap in performance. And
21 also from the AASLD and IDSA that there was an
22 estimated 13 to 18 percent of HCV infected

1 persons who have received treatment. There was
2 also quite a bit of information relative to
3 disparities looking at American Indians and
4 Alaskan Natives that there is the highest
5 incidence of HCV and poorest follow up. And that
6 also African Americans, although comprise 12
7 percent of the United States population, they
8 also have 22 percent of active HCV cases.

9 Minorities clearly show lower
10 treatment rates and so there is a high degree of
11 opportunity for improvement.

12 MS. MUNTHALI: Thank you. Anything to
13 add? Okay. So, we'll vote on performance gap.
14 One high, two moderate, three low and four
15 insufficient.

16 (Voting.)

17 MS. MUNTHALI: Seven high, five
18 moderate and one low for performance gap for
19 Measure 3061. So, we'll move on to specification
20 and we'll ask Amy to tee us up again.

21 MEMBER MINNICH: Sure. And in this
22 regard since it is a trial measure it's just

1 looking at the reference to specificity.

2 MS. MUNTHALI: Steve?

3 MEMBER TEUTSCH: Because this is really
4 talking about either people getting treatment or
5 referral but there can be a big gap obviously
6 between the referral and actually fulfilling that
7 referral and then getting treated. So, I would
8 really like to see some assessment of adequacy.
9 Because follow up is always the horrendous
10 problem on these major public health initiatives.
11 Make sure that things that need to happen
12 actually do happen. So, to the extent that you
13 guys can assess that whether they actually got
14 into care and got treated would be helpful to me
15 because I think referral alone is probably only
16 modestly effective.

17 DR. WARD: Of course, the referral has
18 to happen for the other stuff to happen but we
19 are very interested in monitoring the care
20 cascade it's called from testing to cure and so
21 we're accessing large data bases from health
22 systems as well as from CMS. We also have a

1 cohort study in four sites looking at linkages to
2 care at least in those settings. And even using
3 this commercial lab data as you can track people
4 from antibody, PCR, genotype to borrow clearance
5 and at least three states where we're starting to
6 collect all HCV data, positive or negative, so
7 they can monitor that care cascade within their
8 states by name. Massachusetts, New York,
9 Kentucky and Tennessee. So, maybe that will
10 become a trend in other states.

11 MEMBER TEUTSCH: Yes, that would be
12 helpful. I mean, if you could show that referral
13 that people think this is a high enough risk that
14 they actually -- that's good enough and they
15 actually do follow through then you don't have to
16 monitor all that stuff all the time but my guess
17 is you will.

18 DR. WARD: In the immediate future,
19 yes, absolutely.

20 DR. NISHIMI: So, what I think I heard
21 just so that you're clear here is, what I think
22 the committee will be looking for when you come

1 back, this is your construct is treatment or are
2 referred and I think they would like to see
3 treatment and referred in two different bins so
4 that they can see them to the extent that you can
5 address that issue during your testing since they
6 have the opportunity to comment on it now that
7 would be very advisable.

8 DR. WARD: I think we wrote it that way
9 because treatment is getting simpler so the
10 tester can become the treater and maybe the
11 referral is not as necessary. And so a primary
12 care person can do both with the new drugs which
13 were less of an option with the older ones.

14 MEMBER TEUTSCH: You know, when you
15 look at referred, to me there's two parts. Did
16 the primary physician refer the patient, number
17 one. But number two did the patient go and see
18 the specialist to whom he or she was referred?
19 And, you know, obviously that second one is very
20 important. And, unfortunately, sometimes we
21 don't know and, you know, that goes for any
22 referral across the board and I think more often

1 -- well, maybe things are getting better with
2 electronic health records and communication
3 between specialists and the primary care docs but
4 in the past there's been a lot of referrals that
5 never saw the specialist and that's a big
6 problem.

7 MS. MUNTHALI: Barry-Lewis.

8 MEMBER HARRIS: So, I don't think that
9 it's too far in the past just recently coming out
10 as the chief medical officer for FQHC that part
11 of our measures that we looked at in the FQHC
12 world was whether or not referrals were completed
13 for several different items of care. And so I
14 think that there is the ability to capture data
15 that shows whether or not their referral was
16 completed because that's definitely things that
17 are being looked at now because there's a lot of
18 referrals happening and then they're not
19 completed, as in the language --- I'm not sure if
20 it was this one or the other one where it shows
21 generally five percent actually got the treatment
22 I think I read that right. So, I think that

1 would be important and would be something that --
2 I forgot your name, I'm so sorry.

3 DR. NISHIMI: Robyn.

4 MEMBER HARRIS: Robyn mentioned that we
5 would be looking at coming back for the future,
6 you know, whether or not they received -- they
7 actually follow through even though I as family
8 medicine would have referred but did they
9 actually go to gastro or did they follow my
10 treatment that I would have done?

11 CHAIR MCINERNEY: Thank you.

12 MS. MUNTHALI: No other questions on
13 specification so we can vote. One high, two
14 moderate, three low and four insufficient.

15 (Voting.)

16 MS. MUNTHALI: So, two voted high, nine
17 voted moderate and two voted low so it passes on
18 specifications that are consistent with the
19 evidence. And so we'll move on to feasibility.
20 Amy?

21 MEMBER MINNICH: And so two points are
22 in the feasibility section. One is that the

1 measure specifications were consistent with the
2 evidence. And, secondly, as a committee to look
3 at the denominator exceptions. There were
4 several that were listed under Threats to
5 Validity and we're challenged to look and see if
6 they were appropriately consistent with the
7 evidence and I believe the answer is yes.

8 MS. MUNTHALI: Other comments?
9 Concerns? Okay. It doesn't look like there are
10 any so we'll vote on feasibility. One high, two
11 moderate, three low and insufficient.

12 (Voting.)

13 MS. MUNTHALI: Looking for one more
14 vote. Try again. Okay. So, feasibility for
15 Measure 3061 one high, two moderate, one low.
16 So, the measure passes on feasibility. Oh, two
17 high, sorry, ten moderate and one low.

18 So, usability and use. Amy?

19 MEMBER MINNICH: So, from a usability
20 standpoint the public health issue there is a
21 high opportunity for improvement. Benefits do
22 outweigh consequences and the planned use is for

1 quality improvement and bench marking purposes.

2 MS. MUNTHALI: Okay. No other
3 questions or comments so for usability and use,
4 one high, two moderate, three low and four
5 insufficient. So, we're queuing up the slide.

6 CHAIR McINERNEY: You have the wrong
7 vote up. There it is.

8 MS. MUNTHALI: Okay. So, we're ready
9 now. We'll try again.

10 (Voting.)

11 MS. MUNTHALI: Looking for two more
12 votes. You can try again, two more votes.

13 CHAIR McINERNEY: I have a question. Is
14 there a receiver located in one place and are
15 these things directional?

16 MS. MUNTHALI: No, only there, over
17 here. Over here.

18 CHAIR McINERNEY: Where is a receiver?

19 MS. MUNTHALI: Right here.

20 CHAIR McINERNEY: Oh, so waving that way
21 doesn't help?

22 MS. MUNTHALI: No.

1 CHAIR McINERNY: I've been in the wrong
2 direction all day.

3 MS. MUNTHALI: So, one more vote if you
4 could try again, sorry about that.

5 CHAIR McINERNY: There we go.

6 MS. MUNTHALI: Okay. One high, ten
7 moderate, and two low so for Measure 3061 it
8 passes usability and use.

9 And now we'll assess whether or not we
10 should approve it for trial use and it's one yes
11 and two no.

12 (Voting.)

13 MS. MUNTHALI: So, for Measure 3061,
14 eleven have said yes to approval for trial use
15 and two have said no for approval for trial use.
16 Thank you all. Thank you to the Committee. Thank
17 you, developers for your patience. And I'll turn
18 it over to Tom.

19 CHAIR McINERNY: Well, I think one
20 thing we proved is that the closer the dinner
21 hour gets the faster we vote.

22 Oh, it's time for public comment by

1 the way. Public comment. Any public comment?

2 MS. MUNTHALI: So, Operator if you can
3 open up the lines and then we'll see if anyone in
4 the room has comments.

5 OPERATOR: If you would like to make a
6 public comment please press star 1. And there
7 are no public comments at this time.

8 CHAIR McINERNY: They've already left
9 for dinner.

10 MS. MUNTHALI: Great. So, we are done
11 for today. Tomorrow we reconvene for breakfast
12 at 7:30. Sorry it's early. We have the majority
13 of our new measures and we need to get through
14 them. We're trying to get you guys out of here
15 before the time on the agenda. And breakfast will
16 be at 8:00, and again, reservations ---

17 CHAIR McINERNY: No, breakfast is 7:30.

18 MS. MUNTHALI: Sorry, the meeting will
19 start at 8:00. Breakfast is at 7:30. So, half
20 an hour earlier.

21 DR. NISHIMI: Can I just get a show
22 of -- so the meeting starts at 8:00, breakfast is

1 at 7:30. Can I get a show of hands again to see
2 who is going to dinner? Okay. And then so the
3 restaurant is Georgia Brown's. It is at 950 15th
4 Street. NQF is at 1030 so it's a block down 15th
5 right across from the park there. So, heading in
6 the direction of the park it's right across the
7 park.

8 CHAIR McINERNEY: 950 16th?

9 MS. MUNTHALI: 15th.

10 CHAIR McINERNEY: 15th.

11 (Whereupon, the above-entitled matter
12 went off the record at 5:31 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Health and Well-Being
Standing Committee 2015-2017

Before: NQF

Date: 09-12-16

Place: Washington, DC

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NATIONAL QUALITY FORUM

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HEALTH AND WELL-BEING
STANDING COMMITTEE 2015-2017

+ + + + +

TUESDAY
SEPTEMBER 13, 2016

+ + + + +

The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:00 a.m., Thomas McInerny and Amir Qaseem, Co-Chairs, presiding.

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*** present by teleconference**

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

2 (8:07 a.m.)

3 MS. MUNTHALI: Good morning everyone.
4 I think we're going to get started.

5 Shan, is the public line open?

6 OPERATOR: Yes, ma'am, you are live.

7 MS. MUNTHALI: Okay.

8 Thank you everyone. Thank you for
9 coming back for Day 2 of the Health and Well-
10 Being Standing Committee's In-Person meeting.

11 My name is Elisa Munthali and I'm
12 joined here by my colleagues and our Co-Chair,
13 Tom McInerny and Amir Qaseem will be joining us,
14 he's the other Co-Chair, just after 9:00.

15 We just wanted to very briefly go over
16 -- yesterday was a great day. We reviewed 14
17 measures, which is quite a lot for an NQF
18 committee. And, all but 12 passed with, you
19 know, regular NQF endorsement recommendation.

20 One was recommended with reserve
21 status and one consensus was not reached.

22 And, as we mentioned yesterday, we'll

1 be resolving the consensus not reached issues
2 during the post-comment call.

3 And, so, today, we have ten measures
4 that are under review. All but one of them are
5 new measures. So, we're very happy about that,
6 the potential of new measures coming into the NQF
7 portfolio.

8 So, we'll start with the first one.

9 Tom, I don't know if you have any
10 remarks before we start, sorry.

11 CO-CHAIR McINERNEY: Well, again, I
12 just want to thank everybody and the staff for a
13 great day yesterday and all of their help as we
14 work through a large number of measures.

15 And, I'm so glad that we now have flu
16 vaccine out of the way. I think we've had it up
17 to our eyeballs with flu vaccine.

18 And, I think today, we have some very
19 interesting new measures that'll be -- will need
20 some very good discussion.

21 And, to me, one of the ones that's the
22 most interesting is the first one that we're

1 about ready to consider. As a pediatrician, it's
2 kind of near and dear to my heart. So, let's see
3 how this one goes, please.

4 Thanks so very much.

5 MS. MUNTHALI: Thank you, Tom.

6 So, the first measure is Measure 3071,
7 it's Follow-up Referral After Positive
8 Developmental Screening. It's developed and
9 steward by Northwestern University.

10 And, I'm not sure if Northwestern is
11 here in the room.

12 And, so, as we've been doing with the
13 meeting yesterday, a two to three minute intro
14 and then we'll turn it over to our lead
15 discussants.

16 DR. WOODS: First off, I want to ask
17 if any of the rest of the team is on the phone so
18 that they can contribute.

19 MEMBER AUERBACH: John Auerbach is on.

20 DR. WOODS: Dr. Sachdeva, Dr. Tate?

21 MEMBER AUERBACH: This is John
22 Auerbach. I'm not sure if they'll --

1 DR. WOODS: Hi, John.

2 MS. MUNTHALI: He's one of our
3 committee members. Welcome. Actually, John,
4 while you're on the phone, if you can just
5 introduce yourself before we get into discussion
6 and let us know if there is anything you'd like
7 to disclose.

8 MEMBER AUERBACH: Hello, everybody.
9 My name is John Auerbach. I'm the Policy
10 Director and Acting Director of State, Local,
11 Tribal and Territorial Support at the Centers for
12 Disease Control and I have no conflict to
13 announce.

14 MS. MUNTHALI: Thank you.
15 I'll turn it over to you to see if
16 your colleagues are on the phone.

17 DR. WOODS: Okay. My name is Donna
18 Woods. I'm faculty at Feinberg School of
19 Medicine at Northwestern in the Department of
20 Pediatrics and the Center for Healthcare Studies.

21 So, developmental screening and follow
22 up are fundamental aspects of pediatric care,

1 albeit, very challenging.

2 Thirteen percent of children in the
3 U.S. have developmental or behavioral
4 disabilities and fewer than half of children with
5 delays are identified prior to starting school.

6 When a delaying diagnosis of treatment
7 occurs, critical, often time sensitive early
8 brain and child development opportunities are
9 missed.

10 Currently, in the literature, we
11 understand that 34 to 30 percent, 7 percent, of
12 high risk infants and 61 percent of young
13 children who fail a developmental screen are not
14 referred for any further evaluation or treatment.
15 This is a considerable performance gap.

16 We tested this measure as a chart
17 review measure. The data elements are generated
18 by the healthcare personnel and then the data
19 elements are extracted from the record.

20 We tested this in four institutions in
21 the Chicago Pediatric Quality Safety Consortium
22 which consists of a safety net hospital, a

1 freestanding children's hospital.

2 The primary care networks for this
3 safety net hospital is freestanding children's
4 hospital and two suburban children's hospitals
5 networks as well as Ashe Pediatrics in
6 Pennsylvania.

7 In the testing within the Chicago
8 Pediatric Quality Safety Consortium, performance
9 varied from 31 percent to 100 percent with
10 performance scores of 31 percent, 40 percent and
11 a 100 percent.

12 And, Ashe Pediatrics performance was
13 23 percent.

14 Reliability results, the use of a
15 validated tool was 93.6 percent agreement of
16 patients, with positive developmental screening
17 results had agreement of 99 percent and patients
18 who received a referral for follow up care within
19 seven calendar days of receiving a positive
20 developmental screen had the agreement of 73
21 percent.

22 We tested -- so, that's the results of

1 our testing.

2 And, we also had a stakeholder panel.
3 It included both patient family advocates as well
4 as pediatrician school personnel, early childhood
5 daycare personnel, nurses, physicians,
6 developmental physicians, neurologists, et
7 cetera.

8 All agreed that this was an important
9 measure, that this was consistent with the
10 guideline recommended care for pediatric
11 patients.

12 There's a 2006 guideline that was
13 reaffirmed in 2014, which is the basis for Bright
14 Futures Guidelines and is built on systematic
15 reviews.

16 MS. MUNTHALI: Thank you.

17 So, our lead discussants are Katie,
18 Tom and John. And, I know, John, you have
19 limited time with us, so, perhaps you'd like to
20 start off the discussion on evidence?

21 MEMBER AUERBACH: Let me just -- I'd
22 rather not start only because I didn't join you

1 yesterday. So, maybe someone else can start.

2 MS. MUNTHALI: Okay.

3 MEMBER AUERBACH: And, I will happily
4 join in.

5 MS. MUNTHALI: I think Tom's ready.

6 CO-CHAIR McINERNEY: No, no, Katie just
7 twisted my arm and said she wanted to go first.

8 MEMBER SELLERS: I'm not sure that's
9 exactly how that conversation went. No, I'm
10 happy to.

11 Just, overall, you know, this seems to
12 me to be a very important issue. I think the
13 developers certainly made their case on that.

14 They don't cite evidence regarding the
15 effectiveness of referrals, per se. But, this is
16 kind of similar to a discussion we had yesterday,
17 I think it was regarding Hep C. I mean,
18 certainly, the referral is the next step to
19 getting the needed care. And, they do cite
20 evidence regarding the effectiveness of early
21 intervention.

22 I think the issue with the evidence

1 here is it doesn't quite make it through the
2 algorithm because the evidence is not
3 specifically on the referral, per se.

4 So, when the staff put it through the
5 algorithm, it came out as insufficient with
6 exception. I think the exception being, you
7 know, can we -- knowing that there -- knowing
8 that we don't have evidence on the effectiveness
9 of referral, per se, but, we do have evidence
10 showing that intervention is important.

11 And, we can say from common sense that
12 that referral is a way to get to that
13 intervention. Can we do insufficient with
14 exception rating, thereby, holding providers
15 accountable for doing something without empirical
16 evidence?

17 I'm not sure if I'm articulating that
18 clearly. But, that --

19 MS. MUNTHALI: You are. So, maybe we
20 can pull up the algorithm, it might be helpful.

21 Sheila, can you pull up the evidence
22 algorithm?

1 MS. OGUNGBEMI: It's on our committee
2 home page if you can just go to the general
3 documents at top.

4 DR. WOODS: Also, if I could just
5 speak.

6 Dr. Sachdeva has now joined the call,
7 a member of our team. So, if there are questions
8 for him as well.

9 Dr. Ramesh Sachdeva, who, at the time,
10 was the VP for Quality Informatics at the AAP who
11 is the PI for the Pediatric Measure Center of
12 Excellence.

13 CO-CHAIR McINERNY: Hi, Ramesh, it's
14 Tom McInerny, how are you doing?

15 DR. SACHDEVA: Good morning. How are
16 you? And, I believe Dr. Tate may be joining us,
17 but I don't have confirmation of that. And glad
18 Donna and I be a part of the team that developed
19 this measure.

20 CO-CHAIR McINERNY: So, I'll put in my
21 two cents at this point.

22 You know, this, to me, is a tough

1 measure and I probably have a little bit of a
2 conflict of interest since I'm past President of
3 the American Academy of Pediatrics.

4 But, you know, we do have Measure --
5 I think we approved Measure, a while back, 1448
6 which says that pediatricians and other
7 clinicians who care for children should be doing
8 developmental screening. So, that step is clear
9 and that should take place.

10 We also have evidence that early
11 intervention for children with developmental
12 delays improves the outcome.

13 Unfortunately, what we do not have
14 really good evidence, and this is where the U.S.
15 Preventative Services Task Force weighed in, is
16 the step between the screening and when the
17 patient screens positive and the referral. Does
18 the referral actually lead to an improved
19 outcome?

20 Now, common sense would say, yes, it
21 does. And, certainly, the American Academy of
22 Pediatrics feels strongly that it does.

1 But, then, we have that darn USP --
2 Preventative Services Task Force which, and
3 occasionally, has bothered me in the past about
4 some other measures.

5 But, they really look at things, at
6 evidence, very carefully and very closely. And,
7 I think we do need to pay attention to that.

8 The other point I would like to make
9 is that I'm not comfortable with just -- I think
10 what we're saying is that, in the chart, the
11 patient -- the clinician says patient did not
12 pass the screening test. And, there are several
13 validated, well validated screening tests that
14 are being used as standardized screening tests.

15 And, then, says, patient referred to
16 XYZ for follow up. To me, what really we need to
17 know is, did the patient actually go to that --
18 or say, for further testing at that center?

19 And, I would like to see that there
20 would be somehow in the chart a notation that, in
21 fact, the patient was evaluated. And, then, I
22 think that would make this a much stronger

1 statement, a much stronger measure.

2 DR. WOODS: If I could respond to
3 that? This is one of a set of measures on all of
4 the follow up that is appropriate for the care of
5 a pediatric patient with a positive -- with a
6 developmental screen.

7 One is to have the communication with
8 the family. Afterwards, regardless of the
9 result, this measure, which is about the
10 referral, because, as you can see, referral is,
11 unfortunately, very -- is not happening for 37
12 percent and 61 percent of older children.

13 The third measure, which is currently
14 undergoing further testing is exactly what you
15 said, which is the referral tracking and follow
16 up to make sure that the family actually did
17 follow up and that there has been engaged active
18 further evaluation or treatment.

19 CO-CHAIR McINERNEY: John, do you have
20 any comments about the evidence?

21 MEMBER AUERBACH: Thanks, thanks for
22 asking.

1 I guess I have a couple of questions
2 maybe related to evidence. And, I do apologize
3 that the other people feel like these are self-
4 evident.

5 But, there's some of the questions
6 that I had and just would love to have the
7 developer respond it.

8 You know, the first one is just the
9 seven-day time limit. You know, is there a
10 particular reason for seven day other than that
11 just seems like a reasonable amount?

12 The second question that I have is, is
13 there evidence about, and again, I do apologize
14 when everybody else would say that this is self-
15 evident, is there clinical evidence that a
16 referral is always the appropriate clinical next
17 step as contrasted with, say, the pediatrician
18 scheduling a follow up visit with the patient or
19 monitoring the development over time?

20 In part, I say that because I
21 remember, at times, talking to pediatricians who
22 would say the -- it wasn't clear enough, whether

1 or not this was appropriate for referral and
2 maybe let me monitor it for a little bit longer
3 and have the patient come back, the family come
4 back next month or so?

5 And, then, the third question I guess
6 I have is the evidence with regard to the
7 availability of appropriate referral services if
8 there's evidence about this ready access to those
9 services such that we could have some level of
10 comfort that a referral would be realistic or
11 likely to occur?

12 DR. WOODS: I can respond to those
13 questions. The seven day determination, there
14 was generally believed and thought that a
15 positive developmental screen should receive a
16 referral on the day of the screen.

17 But, there was a recognition in the
18 nature of practice that that was not always
19 possible. So, the expert work group determined
20 that it was -- it would be overly potentially
21 chastising clinicians who had all of the best
22 intentions and all of the best practice that it

1 wouldn't impede the care of a patient if, for
2 some reason, it took a week to get the referral
3 in.

4 So, there's no harm in waiting seven
5 days, however, most should occur within the
6 actual visit period, that actual screening visit.

7 So, that's the answer to your first
8 question. The second question was -- one was
9 about watching and waiting. I think that was the
10 third question. And --

11 MEMBER AUERBACH: Yes, the second
12 question was about -- yes, the second question
13 was about watching and waiting and/or scheduling
14 a follow up appointment with the primary care.

15 DR. WOODS: Correct.

16 It was believed that frequently,
17 inappropriate practice, based on the guidelines,
18 based on the evidence, that it was inappropriate
19 practice to just wait until the next evaluation
20 appointment.

21 If the clinician felt that there might
22 be a reason to wait, it should not go more than a

1 month, that they shouldn't wait through the
2 entire next developmental screen window.
3 Because, as we said, there can be harm due to the
4 time sensitive nature of many developmental
5 delays.

6 And, you had one further question.

7 MEMBER AUERBACH: The availability of
8 referral services.

9 DR. WOODS: So, the requirement is to
10 make a referral. It is not to receive the
11 services of the referral, but it is to make the
12 referral.

13 And, the idea is, again, as soon as
14 possible. And, as you're probably aware, that is
15 particularly in some urban environments, there
16 can be a backlog. So, reaching out as soon as
17 possible is very important.

18 So, these are responses based on
19 expert panel review and determination.

20 MS. MUNTHALI: Other comments or
21 questions on evidence?

22 Steve?

1 MEMBER TEUTSCH: I have two questions.

2 One, John sort of got at and hopefully
3 you can elaborate. Aren't there some of these
4 that the pediatrician can manage themselves so
5 that they don't naturally require a referral?
6 They may have resources within the practice.

7 The other question I had is, this is
8 about referral once kids are detected. Can you
9 say something about how often they're detected
10 using these more formal instruments? I mean, how
11 many are we -- I mean, that's about the
12 denominator for this, right?

13 So, it wasn't clear to me whether
14 there isn't a big gap in just finding them to
15 begin with.

16 DR. WOODS: So, to your first
17 question, if a provider refers within their
18 practice to follow up services, that counts as a
19 referral. And, we actually documented in Ashe
20 Pediatrics how that can occur because they had
21 additional resources within that practice.

22 So, yes, and, it is counted because

1 it's just, you know, the referral is described.
2 Right? So, it becomes clear what the referral
3 is, it doesn't have to go outside of your
4 practice if your practice actually has those
5 services.

6 In terms of what we know about
7 developmental screening with validated tools, the
8 research and the work from Bright Futures, when
9 we started this project, had the rate of children
10 being evaluated using validated tools in the
11 range of 60 percent. And, across the period, it
12 went up into the 80s across the country.

13 However, in our study, we discovered
14 a fairly disturbing disparity in that the safety
15 net providers in our sample, again, only used
16 validated tools about 38 percent of the time.

17 So, when a child is evaluated by, just
18 like, oh, he looks okay or, oh, she looks okay,
19 as opposed to really doing a systematic review, a
20 lot of potential children can be missed.

21 So, we also, as you saw in the
22 denominator, it requires that a validated tool be

1 used to detect a positive screen. Because,
2 otherwise, you can't know that the referral is
3 required.

4 CO-CHAIR McINERNY: Steve, is there a
5 metric? And, do we have a measure, then, that
6 asks about whether they were screened?

7 DR. WOODS: Yes.

8 CO-CHAIR McINERNY: Or using --

9 DR. WOODS: It's already endorsed.
10 It's one of the initial core measures, and so,
11 we're building on that.

12 CO-CHAIR McINERNY: 1448. And, my
13 feeling is that it's about 20 percent of patients
14 who are screened using validated instruments
15 fail.

16 And, then, I think the question is
17 sort of a self-referral. You know, in other
18 words, I say I'm a pediatrician who's interested
19 in developmental problems and I can handle this.
20 I think that's sketchy. Yes, I think that can be
21 difficult.

22 Most of the time, you need physical

1 therapists, occupational therapists, social
2 workers, things like -- psychologists, et cetera.
3 And, most pediatricians don't have those skills.

4 So, I think that would be a little --
5 I don't think I would accept that as a self-
6 referral.

7 MS. MUNTHALI: Arjun and then Jason.

8 MEMBER VENKATESH: So, I guess, on the
9 evidence question, the question I have is, and
10 this is, I think, challenging because, the
11 measure itself is really, really narrow. Right?

12 The measure is about whether or not
13 there's documentation of a referral. It's not
14 all these other things that we want the measure
15 to be that you mentioned, which is the actual
16 completion of the referral visit, something along
17 those lines.

18 And, so, I get that there's not going
19 to be any literature or research on referrals.
20 It's a highly unstudied topic.

21 Is there at least some qualitative
22 work that would suggest that that is the barrier

1 to the follow up? Like something from the
2 patient side that would say, hey, lack of
3 referrals or not being referred is the reason I
4 didn't see somebody.

5 Because, then at least you could say,
6 hey, these referrals, even if there's no evidence
7 for them, because they're never going to be
8 studied, have some notion of potential value.

9 DR. WOODS: Like I just reported, 34
10 to 37 percent of high risk infants and 61 percent
11 of young children who fail a developmental screen
12 are not referred for further evaluation.

13 So, at that point, we know there are
14 a lot of children who aren't getting the services
15 that are required and, actually, honestly, really
16 expected from pediatric care.

17 There's -- from the beginning work
18 we've done on the next measure, which is on
19 referral tracking, let me see if I can find the
20 actual, because I brought it with me just in
21 case, practices that successfully track referrals
22 have found that some families did not follow

1 through with referrals.

2 Tracking referrals led to better
3 communication with local referral sources and
4 more children were identified and linked to
5 services.

6 So, it is the combination of --
7 they're not -- the children are not going to get
8 there if they're not referred.

9 And, then, if the referral is not
10 tracked, appropriate follow up care cannot occur,
11 making sure that the family follows up as well as
12 understanding the nature of the further
13 evaluation or treatment that is occurring for
14 that pediatrician's patient.

15 But, one of the things that we found
16 in the beginning -- the initial testing of the
17 referral tracking measure is so little referral
18 tracking is going on.

19 So, we started with the measures of
20 patients who are referred and we ended up with
21 seven patients in the Chicago Pediatric Quality
22 and Safety Consortium and four in Ashe Pediatrics

1 from over 200.

2 So, you know, we're finding that
3 referral tracking is not occurring either. So,
4 we're having to reselect a sample so that we can
5 start with that referral point.

6 MS. MUNTHALI: Jason and then Tom and
7 the Matt.

8 MEMBER SPANGLER: I want to go back to
9 something Steve mentioned about the measure for
10 actual screening.

11 We're talking about 1448. That was a
12 measure that was supposed to go under maintenance
13 two years ago, didn't. It's time limited. Do we
14 know the status of that and what --

15 Because I know we were waiting for --
16 I'm looking at a report from last year for that.
17 And, I'm just wondering where that is because is
18 that going to disappear?

19 Because, I think that has direct
20 relevance even to this measure because, don't
21 they have a -- there had to be testing done and
22 analysis and --

1 DR. NISHIMI: Yes, Jason, you're
2 correct.

3 That measure, they weren't prepared to
4 bring forward information at this time. So, we
5 gave them another deferral.

6 MEMBER SPANGLER: For how long?
7 Because the last time it was endorsed was 2011.

8 DR. NISHIMI: Right.

9 MEMBER SPANGLER: And, so, we're
10 talking five years now. And, there were two
11 measures that were very similar and I know NCQA
12 pulled their measure which --

13 DR. NISHIMI: They pulled their
14 measure.

15 MEMBER SPANGLER: -- was almost the
16 same.

17 DR. NISHIMI: Right.

18 MEMBER SPANGLER: So, I'm just --
19 because, that's going to affect this -- I mean,
20 there's a relationship between both these
21 measures.

22 DR. NISHIMI: It's unclear whether the

1 developer will be able to obtain sufficient
2 information even by the next cycle. I'm trying
3 to be politic about this, but candid.

4 DR. WOODS: We didn't develop that
5 measure, but we built that measure into our
6 measure. We thought that it has to be the basis.
7 I could provide further information, if that
8 would be helpful to this group following this
9 meeting on what we found regarding the use of a
10 validated tool and additional updates on the --

11 Because there was a reaffirmation of
12 the use of validated tools by both the American
13 Academy of Pediatrics Guideline and also the
14 Bright Futures.

15 MEMBER SPANGLER: Well, my --

16 DR. WOODS: So, the updates are --

17 MEMBER SPANGLER: My concern is not
18 that -- my concern is, I think that's a good
19 measure. My concern is, if you have that measure
20 built into your measure and that measure
21 disappears, that affects your measure.

22 DR. WOODS: It doesn't affect the

1 guideline, though.

2 MEMBER STIEFEL: Maybe dwelling on
3 evidence is appropriate in this one because it's
4 the challenge. And, it seems like a flaw in our
5 process, plucking out a step in a process and
6 evaluating the evidence of that step in the
7 process, I guess, following up from what Amir was
8 saying, it's impossible to demonstrate the
9 evidence of that one step in the process.

10 I'm talking about the screening,
11 referral and referral follow up and plucking out
12 referral and evaluating the evidence for referral
13 is not really -- nor consistent with the sort of
14 health and well-being focus of our work.

15 This step, this measure of a step in
16 a process does not contribute to health and well-
17 being, the whole process does.

18 So, maybe it's just a question about
19 how we handle an isolated measure in a process
20 where the whole process has to take place to
21 improve health and well-being.

22 DR. WOODS: If I could speak to --

1 DR. NISHIMI: No.

2 DR. WOODS: Okay, sorry.

3 DR. NISHIMI: We look at lots of
4 process measures that involve several steps.
5 And, so, it's for the committee to decide whether
6 the step, you know, more distal from the
7 initiation point is the appropriate place to
8 measure and hold providers accountable for.

9 Or, and, there are sometimes is
10 evidence in the series of steps, you know,
11 related to the intervening events. In this case,
12 there isn't for the referral step. So, it may be
13 that the committee, again, votes for evidence
14 with exception. That's why that's an option for
15 you because you feel it is, you know, one piece
16 and it's okay to let it move forward because
17 there isn't that one step.

18 Or, you may decide to wait for, you
19 know, the additional measure that's being
20 developed on actual referral. Or, you can, you
21 know, turn it down in its entirety.

22 CO-CHAIR McINERNEY: Well,

1 interestingly, in the latest issue of AAP news,
2 they do discuss the AAP, it says AAP stands by
3 recommendations on universal developmental
4 screening.

5 And, they say, when a development
6 disorder is suspected, the pediatrician should
7 simultaneously begin the diagnostic process,
8 refer to a specialist for final diagnosis and
9 then refer for therapy.

10 For this process, it is hoped the
11 diagnosis and treatment can be instituted earlier
12 with improved outcomes.

13 So, you know, again, this is more of
14 an expert opinion. There was a policy statement
15 in the AAP made in 2014 that elaborated this.
16 And, certainly, it's sort of the dogma of the AAP
17 and it is in the Bright Futures.

18 For some of you who may not know,
19 Bright Futures is essentially the guideline for
20 how to do anticipatory guidance, screening, et
21 cetera for children and it has been recognized by
22 the CDC and the federal government. It's part of

1 the Affordable Care Act so that all of the
2 recommended procedures, it's in the Bright
3 Futures to be covered at no charge to the
4 patient. That's how strongly it's felt that this
5 is a good guideline.

6 But, again, I think the crux of the
7 matter is that it is based on expert opinion and
8 there is no Grade A kind of evidence by testing,
9 et cetera.

10 DR. NISHIMI: Amir? Amir, I'm sorry,
11 Amir? Arjun?

12 MEMBER VENKATESH: I was just
13 wondering if you guys can -- no problem -- I was
14 wondering if you can scroll on the chart up here
15 to the insufficient evidence page, the next page?

16 And, the reason I think is because
17 what Tom just said, it sounds to me like, for
18 this measure, we are absolutely kind of in Box 10
19 and trying to decide on 10 and 11.

20 Which is that, when you don't have
21 actual empirical evidence, you move off the front
22 page and Box 11 is what allows you to say there's

1 insufficient evidence with exception if there is
2 a national or international consensus
3 recommendation, which is what it sounds like the
4 AAP recommendation is.

5 The question you have to ask before
6 you get to Box 11 is Box 10, and there's an
7 example measure that is sort of similar in
8 construct. But, I think they give the examples,
9 there's a proposal to measure whether blood
10 pressure is assessed each visit instead of blood
11 pressure control.

12 Here, we're trying to measure whether
13 or not a referral is documented, whether or not -
14 - rather than whether or not a referral happened.

15 And, so, the thing I'm a little
16 unclear about is so, if you think that there is
17 another measure already available that does the
18 like blood pressure control, then you would say,
19 yes, and go down and say insufficient is the way
20 I'm reading this.

21 And, so, I guess there's no other
22 measure of right now, anything downstream of the

1 initial screening measure that we reviewed
2 before.

3 And, so, I guess it's no, and then, I
4 would go down that path to rate as insufficient
5 evidence.

6 But, then, I heard that there's a
7 proposal that said, hey, we're working on a
8 measure that's going to be the actual referral.

9 And, so, if you -- if I think about
10 that measure, that they're actually developing a
11 measure about the absolute referral as a
12 committee and if somebody on this, I'd want to
13 say, hey, that's the measure we want. That's a
14 real process measure.

15 This is more of a kind of checkbox or,
16 you know, yes, I documented that there was a
17 referral type measure which is a much lower
18 value.

19 MS. MUNTHALI: So, you should be
20 looking at the measure that's in front of you. I
21 know there are aspirations for Northwestern to
22 develop a measure that's probably going to

1 capture a lot more. But, they've brought forward
2 this measure.

3 So, on the merits of this measure and,
4 Arjun, you're very right about how you go through
5 this algorithm.

6 And, if you -- if the committee agrees
7 as Arjun has said, that, you know, there's an
8 exception to this, then that's the way you should
9 go.

10 But, it is on the merits of this
11 measure.

12 DR. WOODS: Yes, and it is in the
13 initial expectation as a parent, even, we have
14 many parent and family advocates on our group as
15 well as clinicians that their expectation is
16 that, if there's a positive developmental
17 screening, there will be some care for their
18 child. And, they advocate for that.

19 And, it's not the same as blood
20 pressure assessed and blood pressure controlled.
21 Because there is a clear, you know, a clear
22 pathway of treatment.

1 DR. NISHIMI: Is there anything else
2 from the committee? Arjun, was your --

3 Is the committee ready to vote on
4 evidence?

5 Okay, just as a reminder, if we want
6 to consider the orange path here, then to invoke
7 the insufficient with exception, on the first
8 vote overall on evidence, which will be the, you
9 know, high, moderate, low, insufficient vote, the
10 measure needs -- you need to achieve consensus to
11 go down the insufficient route.

12 And, then, we'll hold the second vote
13 on insufficient with exception.

14 So, is that clear to folks? If it's
15 low, if it fails because you think it's low, then
16 we don't march down the insufficient.

17 Okay, go ahead.

18 MS. CRAWFORD: For Measure 3071, we're
19 voting on evidence, one for high, two for
20 moderate, three for low, four for insufficient.

21 We're looking for 16 votes. And,
22 voting is open.

1 (Voting.)

2 We have 0 for high, 2 for moderate, 2
3 for low 11 for insufficient.

4 DR. NISHIMI: Okay, so, we'll vote on
5 insufficient with exception. This is for Measure
6 3071.

7 MS. CRAWFORD: And, our choices are
8 one for high -- no, one or two for Measure 3071.

9 DR. NISHIMI: So, one will be
10 insufficient with exception and two is no
11 exception. So, then, the measure would fail.

12 (Voting.)

13 MS. CRAWFORD: And, one more vote,
14 please?

15 CO-CHAIR McINERNEY: It's like Dancing
16 with the Stars here.

17 MS. CRAWFORD: Ten for insufficient
18 evidence with exception, 5 for no exception.

19 MEMBER SPANGLER: Sorry, this is a
20 process question. Does everybody vote for this
21 or only the people who voted insufficient?

22 MS. MUNTHALI: Everybody.

1 MEMBER SPANGLER: Okay.

2 MS. MUNTHALI: We'll proceed to
3 performance gap. Our lead discussants, Tom, John
4 or Katie?

5 MEMBER SELLERS: Sure, so, moving on
6 to performance gap, right?

7 So, they did their own -- they
8 presented their own evidence on this where they
9 had a very small sample because, I don't -- I did
10 not manage to pull the numbers up in front of me,
11 but, they only wound up with like 16 positive
12 screens in Chicago and maybe 12 in North
13 Carolina.

14 But, they do summarize the literature
15 which shows quite a gap. And, the developer has
16 referred to this a few times in our conversation
17 today.

18 So, it seems there's a gap somewhere
19 in the neighborhood of 35 to -- sorry, only 35 to
20 61 percent of children are being referred after
21 the positive screen.

22 So, they did not present any data on

1 disparities, but it does seem to me like a fairly
2 high performance gap and plenty of room for
3 improvement.

4 DR. NISHIMI: Any other comments?

5 Okay, let's vote on gap. Voting on
6 gap for Measure 3071.

7 MS. CRAWFORD: One is high, two is
8 moderate, three is low, four is insufficient.

9 Voting is open.

10 (Voting.)

11 Fifteen votes are in, 6 for high, 7
12 for moderate, 2 for low, 0 for insufficient.

13 DR. NISHIMI: Okay, so, we'll move on
14 to reliability and validity.

15 MEMBER SELLERS: So, looking at
16 reliability, I think there's a couple of issues
17 here.

18 One has to do with the definition of
19 referral and the other has to do with that small
20 sample size they had for the testing.

21 So, when you look at the way referral
22 is defined, basically, what they have, it says,

1 referral for follow up care is defined as the
2 formal event by which the clinician provides a
3 referral to the patient family. It does not
4 include any further steps in the process like
5 securing the appointment, et cetera.

6 And, refers the patient and family for
7 further evaluation or to any type of therapy,
8 intervention or education to mitigate
9 developmental delays.

10 And, referral can be made within the
11 medical home or outside the medical home. A
12 referral can include the form of watchful waiting
13 by which the clinician offers practice based
14 interventions and schedules the follow up visit
15 within three months.

16 Some referral types are listed below,
17 but this list is not exhaustive. And, then
18 there's maybe 12 different items listed there.

19 So, I think the question is, you know,
20 is this likely to be coded in a reliable manner?
21 And, unfortunately, the testing they provided,
22 you know, because they only found 16 positive --

1 15 positive screens, it's a little bit hard to
2 tell how reliable how this would be.

3 MEMBER VENKATESH: I guess my concern
4 is the fact that they found so few. Doesn't that
5 actually suggest that the reliability is lower or
6 this is where the reliability and validity start
7 to tie together a little bit because the presence
8 of the CPT code is how it's being identified.
9 It's not being currently coded.

10 And, so, I think that we're kind of in
11 this weird box on the reliability one that is --
12 there's no empirical reliability testing.

13 And, then, you're sort of saying,
14 okay, was empirical validity testing or patient
15 level data conducted?

16 And, so, we're kind of going down that
17 path, I think. But, I'm pretty sure that we
18 can't, based on what's here, say that this is,
19 you know, sufficient reliability testing.

20 DR. NISHIMI: So, yes, they did data
21 element level validity testing which we bring
22 forward for the reliability testing score.

1 So, you are correct, they did not do
2 score level reliability testing. They did data
3 element validity testing which NQF qualifies for
4 under the reliability rubric.

5 DR. WOODS: What -- were these school
6 level?

7 DR. NISHIMI: Signal to noise. You
8 would have to have signal and noise and many more
9 entities than this.

10 DR. WOODS: So, five is insufficient?

11 DR. NISHIMI: They're finding to be
12 potential, but, I would be suspicious that you'd
13 be able to do it off of five.

14 Any other questions or comments on the
15 reliability?

16 Ready to vote?

17 MS. CRAWFORD: We're voting on
18 reliability for measure 3071. One is high, two
19 is moderate, three is low, four is insufficient.

20 (Voting.)

21 Voting is closed.

22 Zero for high, 6 for moderate, 7 low,

1 2 insufficient.

2 Forty percent moderate, 47 percent low
3 and 13 percent insufficient.

4 MS. MUNTHALI: So consensus stands.

5 DR. NISHIMI: Consensus not reached on
6 reliability, so we'll proceed to discuss the
7 validity criterion.

8 Right, so, 40 to 60 percent, it's
9 inclusive in that range. So, if it had been 39
10 percent moderate, then it would have failed.
11 But, 40 percent is consensus not reached.

12 So, for validity, Katie?

13 MEMBER SELLERS: Yes, so, with the
14 validity, there are a couple of issues here.

15 One has to do with that specification
16 of seven days. We did hear the rationale for
17 that, which made sense to me.

18 But, on the validity testing, they did
19 it at the level of the measure score and it was
20 face validity only. And, it was done through an
21 open comment period by stakeholders.

22 And, the developer reported more than

1 100 individuals commenting. And, that 65 percent
2 of the respondents agreed that the measure is
3 extremely valid.

4 So, I guess I would like to hear a
5 little bit more about what questions were posed
6 and what the qualifications of the stakeholders
7 reporting on this are?

8 DR. WOODS: We used our broad expert
9 panel network to reach out across the country to
10 a variety of provider associations, to educators,
11 to policy bodies, to patient and family
12 stakeholder and advocacy organizations to make
13 sure we have the broadest review.

14 And, I think we also wanted to,
15 through this process, notify all relevant
16 stakeholders that this was something that was
17 coming down the pike.

18 DR. NISHIMI: Any other questions or
19 comments on validity?

20 MEMBER AUERBACH: When there were
21 questions raised, what was the nature of the
22 questions?

1 DR. WOODS: Oh, gosh, I didn't review
2 that. There were some questions about the
3 watchful waiting, I remember that and what was
4 going to be sufficient for watchful waiting.

5 There were questions about whether a
6 child who already had a positive developmental
7 screen should get a regularly scheduled
8 developmental screen.

9 There was strong advocacy from parent
10 and family organizations that, if the parent --
11 that parents believe that their child, even with
12 a positive developmental screen should have a
13 developmental screen again to review where the
14 child is and that to exclude them would be not
15 good, healthful care and would impede the
16 relationship between the pediatrician and the
17 family.

18 There were two other things, but I'm
19 not -- I'm -- I'll apologize to you right now, I
20 know there were two other things. I can get back
21 to the committee when I get home and review that
22 file.

1 DR. NISHIMI: Arjun and then Ron.

2 MEMBER VENKATESH: I guess the only
3 part about the validity testing, I am -- I
4 totally get face validity and its role in many,
5 many measures require it.

6 The only thing that throws me off a
7 little bit is the question they ask, I think, is
8 whether or not they thought the measure was
9 valid. And, that's a tough term and a tough
10 thing to answer because, we have debates here and
11 like 100-page documents around what is and what
12 isn't validity.

13 And, so, usually, I feel like when I
14 see these face validity surveys, the question
15 that's asked is along those lines is, do the
16 specifications of this measure line up with
17 evidence?

18 And, then, something about the linkage
19 of this measure with an outcome. So, would this
20 measure advance the quality of care or is the --
21 would a higher performance on this measure be
22 associated with better outcomes for children who

1 screen positive? Something like that.

2 And, so, were there any of those kinds
3 of questions in the survey that would just say,
4 there's a linkage between this process and an
5 outcome or that this recommendation lines up with
6 guidelines?

7 I guess they sort of do because they
8 say it's extremely important, but that's sort of
9 loose.

10 DR. WOODS: Yes, there was a fair bit
11 of comment from a wide variety of stakeholders
12 that the way the measure was specified was an
13 appropriate guideline-based, valid, feasible
14 method for assessing what was determined to be a
15 fundamental and critical aspect of pediatric care
16 that is demonstrating very poor performance at
17 this time while being a fundamental expectation
18 of parents and families.

19 DR. NISHIMI: I'm just going to ask,
20 before I go to Ron, NQF requires that for face
21 validity at the measure level, you ask the group
22 whether they think the measure, as specified, but

1 we'll say the measure is score -- the measure
2 score can distinguish good from bad quality and
3 is an, you know, indicator of quality of care.

4 Did you ask about that?

5 Not whether they commented, did you
6 ask that?

7 DR. WOODS: Yes, we did ask if they
8 felt that this particular measure, as specified,
9 could distinguish high versus poor quality
10 performance.

11 DR. NISHIMI: Okay.

12 Ron?

13 MEMBER BIALEK: Do you have data on --
14 excuse me -- the proportion of respondents from
15 suburban, urban, rural and frontier?

16 DR. WOODS: Yes.

17 MEMBER BIALEK: And, then, also, the
18 differences in responses.

19 DR. WOODS: Nothing from frontier.
20 But, suburban, urban and rural, yes.

21 Okay, let me just make sure I'm
22 looking at the right --

1 Rural, 23 percent. We had from one
2 suburban -- what -- performance met the measure.

3 MEMBER BIALEK: I'm sorry, in terms of
4 asking the question about the validity.

5 DR. WOODS: Oh --

6 MEMBER BIALEK: So, I'm trying to get
7 to when you reached to a variety of stakeholders,
8 the -- how many of them, or the proportion, when
9 you did this, how many were urban, rural,
10 suburban? Sorry, yes, suburban? And, then, what
11 the rural response was to the validity question
12 that was just posed.

13 DR. WOODS: I did not do that
14 analysis. I can go back and do that analysis and
15 provide you with more information.

16 We were working with -- I mean, so, we
17 had Head Start and early intervention programs
18 represented in a variety of settings. But, I
19 didn't say early intervention in rural versus
20 early intervention in the city comments or
21 patient advocacy in the rural versus patient
22 advocacy in an urban context.

1 MEMBER BIALEK: Well, it comes down to
2 the provider mix that may exist in rural versus
3 urban and suburban. That's what I'm thinking
4 about is the rural provider, you may have fewer
5 choices and I didn't know if there was a
6 difference in response for validity based upon
7 the rural provider experience.

8 DR. WOODS: There was some little
9 discussion about whether there was better access
10 in rural versus urban environments. And, this
11 was in the expert work group discussion of the
12 results of the public comment.

13 And, there was quite a bit of
14 controversy about whether the urban folks had
15 potentially less access because there was greater
16 numbers of children needing services. And, that
17 the lengths of wait times were -- it was voiced
18 sometimes longer.

19 DR. NISHIMI: Matt?

20 MEMBER STIEFEL: It seems like this
21 discussion of validity rehashes the discussion of
22 evidence and presents the same problem of

1 extracting a step in the process and asking the
2 almost non-answerable question about, is this
3 step in the process valid?

4 I suspect that there's not an
5 exception in terms of our review of validity, but
6 it seems like the same issue that we had with
7 evidence.

8 DR. NISHIMI: Certainly, around the
9 specifications. But, the other question is
10 whether the testing was adequate, so, whether you
11 feel that, you know, face validity was, you know,
12 fine, the process that she described, whether all
13 the threats to validity, which we haven't
14 discussed, but I was going to raise with the
15 committee, have been assessed and you're
16 comfortable with.

17 So, whether their description of how
18 they handle missing data. They could not -- the
19 measure isn't risk adjusted, whether you think
20 that's appropriate.

21 They could not demonstrate meaningful
22 differences among measured entities because they

1 had too few in at the end of the day.

2 So, the question is not just about the
3 validity of the specifications and the evidence
4 underlying that, but also the testing for face
5 validity, meaningful differences, risk adjustment
6 or lack thereof and how they handle the same
7 data.

8 Any other questions on the validity?
9 Committee ready to vote?

10 MS. CRAWFORD: Voting on Measure 3071
11 validity, face validity only, one is moderate,
12 two is low, three insufficient.

13 Okay. Voting has closed at 14.
14 Results, 2 for moderate, 5 for low, 7
15 insufficient, 14 percent moderate, 36 percent
16 low, 50 percent insufficient.

17 DR. NISHIMI: So, the measure does not
18 pass the validity testing.

19 Does the committee have any additional
20 comments that they'd like to convey to the
21 developer beyond those that we've touched upon?

22 I think you heard that there's a lot

1 of interest in this measure. Perhaps if you
2 could beef up that validity testing or NQF's
3 happy to discuss that with you afterwards and
4 maybe a little technical assistance on some
5 construct validity or something like that would
6 be helpful.

7 MEMBER TEUTSCH: I think to get back
8 to Matt's comment, I think if we actually had the
9 whole span here from screening through referral
10 through care and actual improvement, we would be
11 a lot less picky about the steps.

12 And, I think part of this is the
13 artificially dissecting this out and for people
14 like myself who weren't here for all the prior
15 discussions Jason brought up, you know, it's
16 like, wow, wrapping your head around it in
17 isolation is probably not fair when I think we
18 have recommendations that this is a worthwhile
19 intervention. It's important.

20 And, it's more of a thought for NQF
21 than it is for the developer because you're stuck
22 with whatever processes we have.

1 But, thinking about having a more
2 integrated discussion would probably be helpful,
3 at least to people like me.

4 DR. NISHIMI: Well, and they could
5 bring back a measure pair the next time. That's
6 always an option. If the other one had been
7 ready, then they could have paired it with this
8 measure and that probably would have been much
9 more helpful.

10 MEMBER TEUTSCH: I guess, but I heard
11 it's not even their measure, it's a measure from
12 a different --

13 DR. NISHIMI: No, the one they're
14 developing.

15 DR. WOODS: There is a measure that
16 exists for the validated screening tool being
17 used. And, then, there's one that we have
18 developed but the challenge with this particular
19 aspect of care, the performance is so poor that
20 when we started with the use of a validated tool,
21 we got -- starting with hundreds of patients, we
22 got down to just like, four who actually got a

1 referral and got their referral tracked.

2 So, I mean, so, we were surprised by
3 those results. That's why we didn't bring them
4 forward but we have further help from AHRQ to do
5 further testing. And, we'll do further testing
6 on this and maybe NQF can provide us with
7 guidance on how measure pairs work and how that
8 gets reviewed in a committee or how we could
9 prepare that for you.

10 MEMBER TEUTSCH: But, you know, it's
11 really helpful to people like me who are not as
12 deeply immersed as -- if we had that whole sweep
13 of what's going on and we really had a good
14 understanding and that's where Arjun was sort of
15 going.

16 Where is the breakdown in this
17 process? And, I'm hearing from you there are
18 multiple breakdowns.

19 DR. WOODS: Yes.

20 MEMBER TEUTSCH: But, where are those
21 breakdowns and then what are the critical
22 measures that we have to overcome?

1 It would be helpful to figure out, you
2 know, what the -- what to do because, I mean, I
3 know, and I assume I speak for most people here
4 just to -- it's important to get these kids taken
5 care of and because it's important from their
6 perspective, the family, society's perspective.

7 So, I hate to see sort of rules break
8 down the care process.

9 DR. NISHIMI: Arjun? Matt? And,
10 then, --

11 MEMBER VENKATESH: The only thing I
12 was going to add, and I agree with kind of
13 everything that was said there, is that when your
14 next submission in your survey data around face
15 validity testing, it said only 45 percent of
16 people thought that measure was feasible.

17 In some ways, that's -- I don't know
18 how to actually benchmark that because the vast
19 majority of people don't survey and get data on
20 feasibility. But, I would imagine had we gotten
21 to that part of the discussion, people would have
22 been concerned that less than half of people

1 actually thought the measure was feasible.

2 And, I don't know if that's because
3 it's chart extracted or what it is about it, but
4 I would try to get some more information for that
5 part of the application.

6 DR. WOODS: That's misleading in that
7 we specified both it's a chart review measure and
8 was an eMeasure. And, people did not feel it was
9 feasible and when we tested it, it was not
10 feasible as an eMeasure because the elements
11 necessarily for the documentation of this care
12 isn't -- are not in structured variable fields.

13 So, I'm sorry for the misleading.

14 DR. NISHIMI: Matt?

15 MEMBER STIEFEL: As opposed to a
16 measure pair, I wonder if we could consider a
17 measure bundle of screening, referral and follow
18 up as a measure?

19 DR. NISHIMI: Yes, developers -- that
20 would be a composite and the developer is free to
21 submit that kind of thing.

22 MS. MUNTHALI: I just wanted to get

1 back to Steve's point. I had a conversation with
2 Steve and Matt and I -- we are hearing you about
3 understanding the portfolio and understanding
4 where these measures might fit within a spectrum
5 of health and well-being and population health.

6 And, so, we hope to have time, if not
7 today, definitely we're going to dedicate one of
8 our webinars to do that so you can understand
9 where there may be gaps in health and well-being
10 and where this measure and other like measures
11 may fit in.

12 DR. NISHIMI: Okay. Are we ready to
13 move on then to the next measure?

14 Thank you, Donna.

15 MS. MUNTHALI: So the next measure
16 under review is Measure 279, bacterial pneumonia
17 admission rate. This is a PQI 11 measure that is
18 stewarded and developed by AHRQ. It's a
19 maintenance measure and just wanted to give you a
20 little bit of background. This measure was
21 initially reviewed by our Pulmonary and Critical
22 Care Committee, and we asked a couple of you on

1 this committee to provide input from a health and
2 well-being perspective. And it wasn't initially
3 recommended for endorsement by the Pulmonary and
4 Critical Care Committee.

5 At the Consensus Standards Approval
6 meeting where they review the measures and make
7 sure that we are upholding the consensus
8 standards process, the developers, AHRQ, asked
9 for a reconsideration, and the Consensus
10 Standards Approval Committee co-chairs referred
11 it to the Health and Well-Being Committee. It is
12 a population-level measure.

13 I can just share with you some of the
14 concerns that the Pulmonary and Critical Care
15 Committee raised. They felt that there was
16 limited risk adjustment on both age and gender,
17 and they were also concerned about no risk
18 adjustment with regards to poverty level.

19 So the initial votes at the in-person
20 meeting, the measure did not reach consensus on
21 performance gap, validity, and overall
22 suitability. And after it went to comment and

1 the committee re-voted, they did not recommend
2 the measure. So overall suitability, they voted
3 no.

4 So a couple of changes since this
5 measure was reviewed by the Pulmonary and
6 Critical Care Committee. The developers have
7 since changed the name to community-acquired
8 pneumonia admission rate, and so we're bringing
9 this measure in front of you.

10 I just wanted to also let you know
11 that one of the co-chairs of the Pulmonary and
12 Critical Care Committee, Dale Bratzler, is on the
13 phone. And I think he'll be here until about 15
14 minutes. And Robyn was one of the senior
15 directors on the Pulmonary and Critical Care
16 Committee, as well as our other colleague Reva
17 Winkler.

18 And I also wanted to note one recusal
19 on the committee. Arjun was part of the
20 developer team, and so he will not be
21 participating in discussion or vote on this
22 measure.

1 And so, Robyn, I'm not sure if you
2 wanted to add anything.

3 DR. NISHIMI: No. Dale, are you on
4 the line?

5 DR. BRATZLER: Yes, I am.

6 DR. NISHIMI: Great. Was there
7 anything you wanted to say before the Committee
8 began its discussion?

9 DR. BRATZLER: Well, I'm happy to
10 answer questions. I think there were a variety
11 of reasons that our committee did not recommend
12 it for endorsement, and I'm not sure they've been
13 addressed yet.

14 MS. MUNTHALI: Okay, great. Thank
15 you. So right now I'll turn it over to Carol
16 Stocks -- hi, Carol -- who's representing AHRQ,
17 and I think you probably have some other
18 colleagues on the phone. So we're asking
19 everyone to give a two- to three-minute intro of
20 the measure, and then we'll turn it over to our
21 lead discussants on the Health and Well-Being
22 Committee.

1 MS. STOCKS: Okay. I believe we have
2 Sheryl Davies on the phone from Stanford.
3 Stanford is a primary contractor that does a lot
4 of the heavy lifting on the development of
5 multiple -- we have about almost 40 indicators
6 through NQF endorsement.

7 This measure, as with several others,
8 we call our prevention quality indicators, and
9 they utilize hospital-administrated billing data
10 not to measure quality in the hospital but to
11 measure aspects of what's going on with the
12 population outside of the hospital because, as
13 you know, the cases that come through hospitals
14 reflect a good part of what's going on in the
15 community.

16 So I think that, because it's not a
17 direct measure of quality of physician care,
18 there is frequently some confusion about what
19 we're looking at. It's based on the concept that,
20 with adequate healthcare resources in the
21 community, a portion of pneumonia cases,
22 community-acquired pneumonia or hospitalization

1 can be prevented. And it's not a measure of
2 whether appropriate decisions are being made
3 about hospitalization but whether the need for
4 hospitalization occurs.

5 So of course the concept of access to
6 care is very important. And in the past, access
7 to primary care has been pretty much the sole
8 focus. I think we're expanding on our
9 understanding and there's some research to
10 support this that there may be a lot of other
11 factors going on, perhaps access to appropriate
12 home healthcare services or mental health and
13 substance abuse treatment services, a number of
14 things. And it varies by community, so it's
15 designed to look at communities that have
16 relatively high rates compared to other
17 communities. That could be at the county level,
18 the city, or the state level. It's used by many,
19 many state organizations, public health
20 departments, various organizations that monitor
21 the cost and quality of healthcare in their
22 state.

1 The risk adjustment is based on, is
2 only including gender and age at this point. We
3 believe that, of course, anyone who uses the
4 software that comes along with the specifications
5 of this indicator can change that, as they need,
6 for their particular use. But we don't have a
7 more sophisticated risk adjustment because we
8 believe that the general concept is that whether
9 a given population has co-morbidities that are
10 more or less prevalent, the healthcare system
11 should be able to rise to the need and meet those
12 needs. So if you kind of adjust away some of
13 that, it's difficult to get a handle on.

14 And that's for some uses, and, of
15 course, those who are going to compare or do
16 research and want to look at the effects of
17 certain aspects of the healthcare system or
18 interventions that have taken place, then they
19 can utilize more risk adjustment to their needs.
20 I guess that's all I want to say ---

21 DR. NISHIMI: Great.

22 MS. STOCKS: --- if that's okay. I've

1 taken up enough time.

2 DR. NISHIMI: So Committee discussion,
3 and Emilio and Matt. Emilio then Matt.

4 MEMBER CARRILLO: I'd like to ask the
5 co-chair of the Committee that's on the phone
6 what issues were not addressed.

7 DR. BRATZLER: Yes, so this is Dale.
8 So I don't disagree with anything that you just
9 heard from AHRQ, and I'm certainly not opposed in
10 any way to a population-level measure on
11 hospitalization rates for pneumonia.

12 A couple of things that are our
13 committee discussed. So the overall admission
14 rate for pneumonia has been declining, and the
15 evidence for disparities, this was largely based
16 on variations in county admission rates, but even
17 the developer acknowledged that a substantial
18 amount of the disparities, the actual admission
19 rates, between counties was based on the income
20 level of the population. So it seems --- I kind
21 of get this concept of not adjusting for poverty
22 levels, but, yet, that's what's driving most of

1 the disparities in the admission rate, even by
2 AHRQ's own submission, admission with respect to
3 the information.

4 The other thing is I think our
5 committee talked a lot about, you know, even
6 though this is a population health measure and
7 it's all about changes to public policy,
8 community-based interventions that might reduce
9 hospitalization rates for pneumonia, in reality
10 there was no evidence presented in any of the
11 references or anything else that you could
12 actually do anything about those particular
13 policies or any evidence that changing those
14 policies would actually change admission rates.
15 When you look at the reference list that was
16 provided, there were about 23 references.
17 Thirteen of them focus on whether or not to give
18 influenza pneumococcal vaccine, and our committee
19 completely agrees that that's very important.
20 That definitely reduces admission rates, and we
21 have nice process of care measures for multiple
22 settings of care now around influenza

1 pneumococcal vaccination rate.

2 But all the rest of the references
3 that were provided were simple observational
4 studies simply highlighting what the differences
5 are that might be associated with higher rates of
6 admission for pneumonia. So certain patient-
7 level characteristics, population-based income
8 rates clearly significantly associated with
9 hospitalization rates. You know, so I guess if
10 it's just a measure to look at population-level
11 measures and compare counties, I mean, frankly,
12 you could highlight that most of the variation
13 between counties is being driven by income
14 levels. And those, as you know, are very
15 difficult to change, particularly for the
16 healthcare system.

17 And then, finally, I'll make this
18 point. I know it may not be relevant, but it
19 came up frequently in our conversation that there
20 is one unintended consequence of this metric, and
21 it is highly used for accountability at the
22 practice level. And I know that wasn't AHRQ's

1 intent, but that's what's happening. It's now
2 being used for the value modifier, QRURs, other
3 reports that are being used at the practice level
4 by a variety of payers, not only CMS. And that I
5 know wasn't the intent of the population health
6 measure, but that was certainly discussed
7 extensively by our committee.

8 DR. NISHIMI: So that would be a
9 usability and use issue for you to keep in mind.
10 Emilio, anything else?

11 MEMBER CARRILLO: No, I think, in
12 terms of, just to accentuate what you said, the
13 issue of access is central to the rationale for
14 the measure. And income has all to do with
15 access.

16 DR. NISHIMI: Matt, as one of the lead
17 discussants, and then I'll go to Amir.

18 MEMBER STIEFEL: Are we going
19 systematically through, are we starting with --

20 DR. NISHIMI: So we're starting with
21 evidence, if you have any. But, first, if you
22 had any questions for Dale -- I'm sorry --

1 because he's leaving.

2 MEMBER HILL: I was just wondering if
3 our colleague on the phone could tell us what the
4 role of antibiotic resistance is, in their view,
5 with this particular measure.

6 DR. BRATZLER: Yes, so this is Dale
7 again. I don't know that we ever discussed this
8 and, honestly, I don't know, I'm not aware of any
9 specific information about antibiotic resistance
10 driving actual hospitalization rates. One other
11 problem I didn't mention with the metric is that
12 we know, I've been studying pneumonia since the
13 late 90s, and we knew that more than half of
14 patients admitted to the hospital did not have a
15 bacterial culture when they were admitted with
16 pneumonia. And I think what's coming out now
17 through a variety of different forms of research
18 is that there are a whole host of viruses that
19 are causing pneumonia, but I suspect they often
20 get coded as organism unknown, and they may end
21 up being drawn into this particular denominator
22 for this measure.

1 So, as an example, we know respiratory
2 syncytial virus actually is emerging as a fairly
3 substantial risk for elderly for hospitalization
4 for pneumonia. I don't know of any way to
5 prevent it, and, yet, I suspect that, unless
6 you're doing PCR testing for RSV, the diagnosis
7 is often missed, so these cases get, you know,
8 incorrectly coded as potentially organism unknown
9 cases.

10 So the epidemiology of pneumonia is
11 simply on the basis that we have better testing
12 now for viral forms of pneumonia is changing.
13 But I'm not aware of any antibiotic resistance
14 issues that impact hospitalization rates. We
15 didn't discuss that.

16 DR. NISHIMI: Any other Committee
17 questions for Dale? He does have to leave, so I
18 want to make sure you have the opportunity.
19 Matt?

20 MEMBER STIEFEL: To summarize what I
21 think we've heard is the concerns relate to the
22 appropriateness of adjustment for income; second,

1 the lack of evidence of the relationship between
2 policy changes and reductions in admissions; and
3 the third is the level of accountability for this
4 measure and the appropriateness of accountability
5 at the practice level.

6 DR. NISHIMI: Anything else?

7 DR. BRATZLER: Yes, I think those were
8 the key issues. Again, I mean, I think promoting
9 vaccination, which there's tons of evidence for,
10 everybody agreed with, and there was extensive
11 discussion about literature in the applications.
12 But, you know, the lack of adjustment for poverty
13 was a big concern.

14 And the other one that I'll just
15 mention, I'm reading back through our actual
16 notes, was acute illness burden that's not
17 uniform across geographic areas. Again, there's
18 no risk adjustment for patient severity of
19 illness or underlying illness. So we know that
20 diabetics, COPD patients, and others have higher
21 rates of admission for pneumonia. What we don't
22 know is, I mean, what's not included in the

1 measure is that there's no discussion of
2 variations in those actual underlying risk
3 factors based on county-level data.

4 DR. NISHIMI: Okay. Thanks so much,
5 Dale. Amir?

6 CO-CHAIR QASEEM: So just a quick
7 question. I think everything has already been
8 addressed about this measure, and apologies for
9 my being late. One question that I had was, I
10 mean, I think we all understand that reducing
11 hospitalizations is important. What I did not
12 see in this measure is that reducing
13 hospitalizations lead to better clinical outcomes
14 for patients with bacterial pneumonia. Is that
15 an assumption that you had behind this measure?
16 I'm not aware or have seen evidence for that.

17 DR. NISHIMI: Dale?

18 DR. BRATZLER: Yes. So, yes, that's
19 a good --- I'm trying to drill through my mind
20 here and see if I can think of anything. I don't
21 know that that's, I don't know that there's any
22 evidence of reducing hospitalizations changes

1 outcomes. I mean, there are a lot of patients
2 that probably -- I completely agree with AHRQ on
3 the point that there are a lot of patients that
4 probably get admitted to the hospital that can be
5 treated in the ambulatory setting using
6 appropriate risk stratification tools. So I
7 certainly agree with that.

8 And the other thing that AHRQ
9 demonstrated very nicely in their application was
10 that there is substantial variation in
11 hospitalization rates across counties. I mean,
12 there's a fairly wide spread of the admission
13 rates. But I think our primary concern was, was
14 that a big driver of that disparity or those
15 differences between county rates was income level
16 in the county. And from a policy standpoint, I'd
17 love to fix that. I'm not exactly sure how.

18 But in terms of changing patient
19 outcomes, you know, I think anytime we can keep
20 people out of the hospital is probably a good
21 thing to do. But whether that's been studied
22 explicitly for pneumonia about whether you can

1 reduce mortality by keeping out of the hospital,
2 I'm not aware of any studies.

3 CO-CHAIR QASEEM: And that's why it
4 needs an outcome measure, Dale. And my concern
5 was are we going to end up with some unintended
6 consequences, patients who should be getting
7 treated actually now is going to have worse
8 outcomes because now you're trying to reduce
9 hospitalization rates. For an outcome measure, I
10 think that was an important one to have it in
11 there, and that's why I was bringing it up.
12 Maybe it has already been discussed before
13 earlier, I don't know. But anyways . . .

14 DR. BRATZLER: Well, we certainly
15 didn't discuss that.

16 DR. NISHIMI: Steve and then Tom.
17 Sorry.

18 MEMBER TEUTSCH: So as I heard this,
19 this is a community-level measure, not a
20 hospital-specific or clinical-specific measure.
21 And I guess it troubles me a little bit to think
22 that we can't do anything about many of the

1 things that are related to those income gaps, and
2 I wouldn't adjust for them because they can be
3 addressed.

4 I'll just give you a simple example.
5 Medicaid expansion. Maybe a lot of these folks
6 don't have access to adequate care because they
7 can't get coverage. Those are policy decisions
8 at a community level. Availability of services.
9 Now, whether the community-acquired pneumonia
10 admissions is the best measure of those things,
11 we could discuss how best to get at them. But
12 I'm not really disturbed about having these
13 things when we need to keep it in front of the
14 healthcare system and the community that there
15 are solvable social and economic approaches, as
16 well as clinical approaches. And we heard about
17 some of them in terms of immunization. We've got
18 a variety of approaches to that that really
19 should be addressed and probably need to be
20 addressed not just within the clinical care
21 system but at the community level because many of
22 these events, I suspect, occur among those people

1 who are really not within the healthcare system
2 very well.

3 So I guess, you know, I don't know
4 what the evidence for it is, but I think we have
5 to think a bit more broadly about what we want
6 these measures to do, who is the organization,
7 what are the organizations or entities that need
8 to take responsibility because my definition, at
9 least, of the health system, not the healthcare
10 system, embraces a much broader group of
11 stakeholders, many of whom would not see
12 themselves as healthcare oriented, who need to
13 embrace these things and realize that we're
14 paying the price in many of these metrics, and
15 I'm sure CAP isn't the only one that we would
16 think about at a population level.

17 And I'd even dispute diabetes and
18 other underlying diseases which have, you know,
19 can be, in large measure, prevented with better
20 clinical care and with more attention to obesity,
21 nutrition, parks, soda taxes, you know, all this
22 stuff. So I think it's important to keep it in

1 front of us, even though I wouldn't say it's up
2 to the pulmonologist to solve it.

3 CO-CHAIR McINERNEY: Well said, Steve.
4 I have two comments about the hospitalization.
5 One, it increases expense, and so that's a
6 problem and you'd want to try and avoid
7 hospitalization for that reason. And, two, it
8 increases the risk of the patient for having some
9 morbidity and/or mortality from hospital-acquired
10 infections and other untoward events that occur
11 in the hospital. So another reason why we'd
12 probably want to reduce hospitalization for these
13 patients.

14 DR. NISHIMI: Okay. I think we're
15 ready to start marching through. Thanks so much,
16 Dale. We appreciate your time this morning.

17 DR. BRATZLER: Okay. Thank you.

18 DR. NISHIMI: Elisa reminded me that,
19 before we go on, Amir, our co-chair, has arrived.
20 And, Amir, for the record, we need you to
21 introduce yourself and whether you have any
22 conflicts.

1 CO-CHAIR QASEEM: Sure. Again,
2 apologies from my end. I had a scheduling
3 conflict. Amir Qaseem. I'm Vice President of
4 Clinical Policy at the American College of
5 Physicians. I don't have a conflict, but, I
6 think probably more for disclosure, I am on the
7 board of trustees or regents of directors,
8 whatever their governing board is at the PCPI.
9 But they don't have any measures, so it's not a
10 conflict.

11 DR. NISHIMI: Okay. So the first
12 criterion that we need to address is evidence.
13 This is an outcome measure, so it is a yes/no
14 vote. This is a maintenance measure, so the
15 previous committee said it was yes and the
16 Pulmonary Committee, in its deliberations, didn't
17 further discuss and vote, so they said yes. And
18 so the question is, is this committee comfortable
19 with just suspending the vote, we sort of had a
20 discussion already, and moving on to the next
21 criterion?

22 MEMBER SPANGLER: Well, I have a

1 question. They said yes. I thought they didn't
2 reach consensus and then, when they discussed it,
3 they didn't recommend it.

4 DR. NISHIMI: They didn't recommend
5 the measure as a whole, but they didn't discuss
6 evidence.

7 MEMBER SPANGLER: Oh, okay, got it,
8 got it, got it.

9 DR. NISHIMI: Yes, they didn't discuss
10 this criterion. So then let's move to gap.
11 Emilio, Matt?

12 MEMBER CARRILLO: There is a gap that
13 has been noted, and, again, the questions, in
14 terms of the stratification of the measure are
15 very important, including socioeconomic status.
16 So we have data provided. County to county,
17 they're significant. That's been pointed out
18 already. There is significant gaps that have
19 been noted and well documented.

20 MEMBER STIEFEL: And that there are
21 interventions that would reduce this admission
22 rate.

1 DR. NISHIMI: Any other questions or
2 comments on gap? Are we ready to vote on gap
3 then?

4 MS. CRAWFORD: Voting is open on
5 Measure 0279, performance gap. One is high, two
6 is moderate, three is low, four insufficient, and
7 we're waiting for 16 votes. Fifteen votes. One
8 more. Everyone hit their clickers again. Oh,
9 then 14 is what we're looking for. Okay, one
10 more. Okay. Can everyone, like, point towards -
11 - oh, that's recused. I'm sorry. Thank you.
12 Well, 14 it is.

13 Okay. Five voted high, nine moderate,
14 zero low, zero insufficient. Thirty-six percent
15 high, sixty-four percent moderate.

16 DR. NISHIMI: Okay. So let's move on
17 to scientific acceptability. Matt, Emilio, Amir?
18 Any comments on the reliability?

19 MEMBER STIEFEL: Reliability testing
20 was done with a high signal-to-noise ratio, 0.97.

21 MEMBER CARRILLO: I agree.

22 DR. NISHIMI: Any other questions on

1 reliability and other Committee comments? Okay.
2 We'll vote on reliability.

3 MS. CRAWFORD: Voting is open on
4 Measure 0279 on reliability. One is high, two
5 moderate, three low, four insufficient. We're
6 waiting on 14 votes.

7 Voting has ended. Seven high, seven
8 moderate, zero low, zero insufficient.

9 DR. NISHIMI: So consensus is not
10 reached, so we'll continue -- oh, it is? Oh, I'm
11 sorry. It's high. I don't have my glasses on.
12 It's high and moderate. Okay. So 100-percent
13 consensus on reliability, so the next question is
14 validity. This is where the Committee might want
15 to discuss the risk adjustment issues that Dale
16 Bratzler raised. Matt and Emilio?

17 MEMBER CARRILLO: Well, as has been
18 pointed out, the issue of access, which is very
19 important to this measure, is clearly strongly
20 associated with socioeconomic, and there's also
21 the issues of diabetes and COPD that are very
22 critical to the measure that should be included

1 and stratified. So I think that there are some
2 challenges to validity.

3 MEMBER STIEFEL: And my opinion, in
4 terms of the concern expressed by the previous
5 committee of the lack of adjustment for SES or
6 income, I disagree with, I think it would not be
7 appropriate to adjust for income for some of the
8 reasons that Steve articulated.

9 DR. NISHIMI: Marcel?

10 MEMBER SALIVE: Also, I think, you
11 know, there are some points that weren't made.
12 One is that not just, you know, are there
13 interventions, but I think that highlighting
14 differences in different states, you can look at
15 some of the policies that are in place and
16 whether they would have an effect because, as
17 Steve said, you know, there's different Medicaid
18 eligibilities in different states. So there are
19 some natural experiments that could be looked at
20 with the data, and so I think it's very valuable.

21 And, finally, I think, you know, at a
22 population level, this type of adjustment is

1 just, you know, gilding the lily and really is
2 not necessary.

3 MEMBER TEUTSCH: I would say it's not
4 only gilding the lily, it masks real differences
5 that need to be addressed.

6 DR. NISHIMI: Anything else? Okay.
7 We're ready to vote on validity for 0279.

8 MS. CRAWFORD: One is moderate, two
9 low, three insufficient. Voting is closed. Nine
10 moderate, five low, zero insufficient. Sixty-
11 four percent moderate, thirty-six percent low.

12 DR. NISHIMI: Okay. We'll move on to
13 feasibility.

14 MEMBER CARRILLO: Feasibility I think
15 has been established by the previous committee,
16 and I don't think that there's any issues there.

17 DR. NISHIMI: Okay. So Matt agrees.
18 Any other comments or questions on feasibility?

19 MS. CRAWFORD: Voting is open on
20 Measure 0279. One is high, two is moderate,
21 three is low, four insufficient. One more vote.
22 Eleven high, two moderate, one low, zero

1 insufficient. Seventy-nine percent high, fourteen
2 percent moderate, seven percent low, zero percent
3 insufficient.

4 DR. NISHIMI: Okay. And then the last
5 criterion is usability and use. Again, this
6 measure is specified and AHRQ puts it before you
7 as a county-level measure. You heard from Dr.
8 Bratzler that there was, in that committee's
9 view, an unintended consequence of the use of
10 that measure at the provider level. Any other
11 comments, Emilio or Matt or Amir?

12 MEMBER CARRILLO: I just want to
13 perhaps raise the question is this an issue
14 that's found with other PQI measures, as well,
15 that this sort of slippery slope to a provider
16 focus? If anybody could comment on that.

17 MS. STOCKS: Could I say something
18 about that? In terms of the CMS use of this
19 measure, and I think that's kind of at the root
20 of the comments, they don't use this measure as
21 we specify it. They have adapted it in two or
22 three different ways with a different denominator

1 and different numerators. So even though they're
2 called PQIs and they rely on some of our
3 scientific evidence, we consider them a little
4 bit different measure.

5 CO-CHAIR QASEEM: So that was my major
6 concern when I was talking about the outcome
7 measure. What just Carol said, those of you who
8 are involved with MACRA measures or any of the
9 measures that are not getting implemented, they
10 are approving these measures that say county
11 level but they are getting implemented at
12 individual physician level or level where they
13 have never been tested or we don't have any data
14 that they will improve the outcomes. It goes
15 back to what Steve was talking about. At county
16 level, I absolutely understand for this measure,
17 and you're going to hear me say it many times
18 today because I just came back from a MACRA
19 meeting, as well. It is just very concerning for
20 me how CMS is not only not looking at what level
21 these measures are getting improved, they're not
22 even including the measures that are NQF

1 endorsed. That's a separate debate, and we're
2 not going to get into it.

3 I don't have a solution. I want to
4 look at Elisa and the NQF staff. I have been
5 saying this forever, but my worry is that no one
6 is really hearing us out.

7 MEMBER TEUTSCH: But is this unique to
8 this measure with the QRUR or other --

9 CO-CHAIR QASEEM: It's a measure-level
10 problem. It doesn't matter which measure it is.

11 DR. NISHIMI: Steve?

12 MEMBER TEUTSCH: A couple of thoughts
13 on that because I agree that people misuse
14 statistics, data, all the time, and somehow we
15 can't protect people from that. That's too bad.
16 We can educate them, all that sort of thing.

17 A couple of things to think about,
18 though. One is the criterion we saw earlier was
19 about healthcare. This should be about a health
20 system more broadly, which might take it at least
21 out of, at least partially out of the healthcare
22 system, certainly part of that. That's one.

1 The second is this is just one of a
2 portfolio of measures that reflect the general
3 kinds of underlying socioeconomic, health system,
4 financing issues that we can monitor within the
5 healthcare system. And one thing to think about
6 is to put forth a portfolio of these things. So
7 rather than sort of reporting this in isolation,
8 if we had a set of these things that we think are
9 driven largely outside of the clinical care
10 system or at least substantially and actually
11 said, whether you look at CAP or Y or Z, that you
12 see the same phenomenon because the interventions
13 for them are, you know, in many cases, broader.
14 I mean, you could speak about diabetes and COPD,
15 but you know, smoking and diet, those affect lots
16 of stuff and lots of outcomes. Same thing with
17 the payment system and whatnot.

18 So I wonder if we can, at some point,
19 put out some sort of a portfolio of these that
20 would be at, say, a county, a state, or regional
21 level, whatever it is, that then paint a picture
22 that allows people to get a better idea; and,

1 hopefully, some of the adverse consequences Amir
2 is talking about could be at least ameliorated a
3 little. But you can't help people from using
4 things for which they aren't intended, but at
5 least you can make steps in that direction.

6 MS. MUNTHALI: Yes, I think that's a
7 very good idea, actually, as we talk about our
8 portfolio and how these measures may fit into it
9 and where these measures, where the locus of
10 accountability. I mean, this is part of what has
11 happened with how these measures have been
12 adapted for use. And you're very right. It's
13 very much out of our control. What we have asked
14 you to do is evaluate these measures against our
15 criteria on the merits, the scientific merits of
16 the measures, but they're going to be used. And
17 part of that conversation is part of NQF's work
18 around the Measures Applications Partnership.
19 These conversations happen frequently that the
20 measures be placed in programs in which they have
21 been specified for.

22 With that said, I can tell you we're

1 having some pretty significant conversations with
2 CMS about, you know, measure use and making sure
3 that the appropriate measures are placed in
4 programs. But it's not just in federal programs.
5 These measures are being adapted at local levels,
6 at state levels for a number of reasons. We're
7 undertaking some work around measure variation,
8 talking, we've started to identify what are the
9 reasons for a variation, why does it happen, how
10 can we mitigate it?

11 And so we recognize that that's a
12 significant issue in measurement. Not much we
13 can do, but we are starting to actually make some
14 inroads towards coming up with a solution, but
15 it's going to take all of us to do that. Matt?

16 MEMBER STIEFEL: The issue is the
17 issue Amir raised about using hospitalization as
18 a surrogate measure for the health and well-being
19 measure of the progression of pneumonia. And
20 it's hard to hold the message hostage to its
21 misuse downstream. And so this is a challenging
22 question. It may be the best surrogate we have

1 for a population health measure of progression of
2 pneumonia, and I think, I guess in my opinion,
3 the misuse issue is an issue that Elisa was
4 talking about in terms of sort of downstream of
5 the measure approval.

6 CO-CHAIR QASEEM: Just one general
7 comment, Elisa, to respond. Is that a
8 possibility, because some of the richness of the
9 conversations that we have in this committee and
10 other NQF committees, I think it tends to
11 disappear by the time CMS hears about it. Things
12 as of nature that this measure and other
13 measures, too, if we're approving a measure at a
14 community level, there is also discussion
15 happening that this is not being approved at the
16 individual physician level. Shouldn't we have
17 something along the lines that we can have that
18 as an option or something, so we can at least go
19 back to CMS saying -- because CMS says something
20 else. They say, well, your committee actually
21 approved this measure.

22 MS. MUNTHALI: So they're listening,

1 trust me. We have our CMS contract leads are
2 listening to this conversation right now. AHRQ
3 is a federal partner of CMS's. I think there
4 need to be some discussions that happen between
5 AHRQ and other agencies that are developing
6 measures with CMS. We're all in it together. We
7 understand, you know, they're trying to put
8 together programs for different settings.

9 So I can tell you they're listening.
10 We will include this conversation in the report.
11 We're going to have conversations. I asked our
12 contract lead at CMS to join this conversation,
13 so I know she's on it, and I'll be following up
14 with her, as well, because we do know that this
15 would be a significant issue.

16 But it's not just PQIs, it's not just,
17 you know, this committee. It happens across
18 committees, and it's a big concern of all of
19 ours.

20 CO-CHAIR QASEEM: So I don't want to
21 derail the conversation. I want to get going
22 onto voting, but would it be okay if I put the

1 CMS person on the spot and asked them to respond
2 to this issue? I don't know who is on the call.

3 MS. MUNTHALI: Maybe not put her on
4 the spot. Sophia Chen, are you on the call?
5 Operator, is Sophia Chen on the call? And if she
6 is, could you open her line?

7 OPERATOR: She has not joined.

8 MS. MUNTHALI: Okay. So somebody is
9 on here that's listening. But trust us, we'll
10 communicate this.

11 CO-CHAIR McINERNEY: So to follow-up on
12 what Steve I think so importantly pointed out,
13 Rochester has made the claim that they will be
14 the healthiest community in the country in 2020.
15 But do we have any measures that would be able to
16 refute or approve that claim? That's what you're
17 talking about. We need a portfolio.

18 MEMBER TEUTSCH: So I don't know if
19 you want to get into all this. I can spend a
20 long time on this. So we can discuss what the
21 healthiest community is.

22 So I was involved with the IOM report

1 on public health strategies, and we set a goal,
2 and made a recommendation. The secretary set a
3 goal that we would be average in terms of the
4 other developed nations, in terms of cost and
5 life expectancy. I don't remember if we did
6 others, you know, because there's a whole series
7 of metrics. I think it was just life expectancy.

8 That was an enormous stretch for us to
9 become average by 2030. And, you know, we could
10 discuss what it is, and Matt has a well-being
11 measure, we have life expectancy, infant
12 mortality, maternal mortality. We have lots of
13 metrics we can use. We can come up with
14 composites. I know there are states that are
15 using America's Health Rankings, I know that
16 there are places using county health rankings.

17 So my concern isn't that we don't have
18 metrics. I think we can find them. I think what
19 we lack is a common purpose and will and a
20 willingness to actually focus on that and what
21 are the major drivers of health, which is about
22 20 percent in the healthcare system, it's about

1 40 percent social factors, 30 percent behavioral,
2 and 10 percent environmental. And I think it's
3 unfair to ask the healthcare system to solve all
4 these problems, but if we don't engage the
5 healthcare system in thinking more broadly and
6 helping support those initiatives that deal with
7 those underlying drivers, we're not going to get
8 there.

9 So, sorry, that's a soliloquy, a
10 little political, but that's sort of where I am
11 in all of this.

12 DR. NISHIMI: Okay. Is the Committee
13 ready to vote on usability and use?

14 MS. CRAWFORD: Voting is open. One is
15 high, two moderate, three low, four insufficient
16 information. Three high, eight moderate, three
17 low. Twenty-one percent high, fifty-seven
18 percent moderate, twenty-one percent low.

19 DR. NISHIMI: Okay. Final vote on
20 overall suitability for endorsement. Is there
21 any discussion? Okay. Voting on 0279, overall
22 suitability for endorsement. One yes, two no.

1 MS. CRAWFORD: Just one more vote.
2 Twelve yes, two no. Eight-six percent yes,
3 fourteen percent no.

4 DR. NISHIMI: So the Committee
5 recommends 0279 for endorsement. Thank you,
6 Carol. You had to do this before two committees.

7 MS. STOCKS: Thank you. Thank you for
8 the lively discussion, too.

9 DR. NISHIMI: And I think if you, you
10 know, obviously, you heard the Committee had some
11 similar concerns about working with CMS on the
12 communication.

13 Okay. Next measure, 3067. Patricia,
14 Steve, and Michael had an emergency, and so he's
15 not here.

16 CO-CHAIR QASEEM: So any comments,
17 Steve or Patricia?

18 MS. MUNTHALI: We'll actually start
19 off with an introduction by the developer.

20 CO-CHAIR QASEEM: Oh, sure.

21 MS. MUNTHALI: And this is CDC. It's
22 a new measure. It's HIV infection screening.

1 And, Abigail, if you can turn on the mike.

2 MS. VIAL: All right, okay. I can
3 figure this out. Hi. So I am Abigail Viall. I
4 am from CDC's National Center for HIV/AIDS, Viral
5 Hep Atitis, STD and TB Prevention. You saw one
6 of my colleagues yesterday, John Ward. And we
7 are here to discuss, actually our center has put
8 forward both the HIV screening measure and the
9 measure that follows, the viral load suppression
10 measure.

11 The HIV screening measure is an
12 eMeasure. It is intended to improve
13 implementation of CDC's and subsequently USPSTF
14 recommendations that all persons between the ages
15 of, for the USPSTF, 15 and 65 should be screened
16 at least once for HIV in their lifetime. It is
17 an ever measure, and that has proven challenging
18 in discussions in the past. We have had a great
19 deal of deliberation before we ever brought this
20 forward, and I'm eager to engage with the panel
21 on that. But we feel that, given the fact that,
22 despite having had a CDC recommendation to this

1 effect for over ten years and the USPSTF
2 recommendation similar to this for at least three
3 years and the fact that the rates for people who
4 have ever been tested for HIV continue to just
5 inch up slowly, that having a measure that would
6 help people with the implementation and help sort
7 of focus implementation of this recommended
8 service would be helpful.

9 And I believe I have several
10 colleagues on the phone. Will they be able to
11 get through? Okay. It's Cal Ham, Eileen Wong,
12 Wendy Lyon, Kaijie. I think that, for this
13 measure, that's enough.

14 DR. NISHIMI: So, operator ---

15 (Simultaneous speaking.)

16 DR. NISHIMI: --- could you make sure
17 those lines are open?

18 OPERATOR: All lines are open.

19 DR. NISHIMI: Thank you.

20 MS. MUNTHALI: So Steve and Patricia.

21 MEMBER TEUTSCH: I think the evidence
22 that, you know, testing and getting people into

1 care, is obviously there, we have those
2 recommendations. What I'm just wondering about
3 was, I mean, we'll get to the ability to measure
4 this in a minute, but to what extent will we have
5 the same question about referrals as we had
6 before? Just testing obviously isn't adequate,
7 right? You've got to get people into a process
8 of care. You were sitting here, so you heard the
9 discussion and I'm not going to repeat it, but
10 it's largely the same set of issues: how do we
11 know that then, after testing, to what extent do
12 the right things actually happen?

13 MS. VIAL: That is a good question,
14 and I did hear the discussion. I can say that,
15 from our surveillance data, we currently believe
16 that at least 70, I think 73 to 74 percent of
17 people are linked to care, linked, not referred,
18 linked to care within three months of their
19 diagnosis. This has been a huge push in the HIV
20 community to make sure that diagnoses lead to
21 linkage, and, in fact, most states are now using
22 their surveillance systems to check if a

1 diagnosis, when they receive a diagnosis, it is
2 followed by a viral load or CD4 measure within,
3 well, now, actually under the new NHAS update,
4 within one month after diagnosis.

5 So we're monitoring that at a public
6 health level. At the measure level, I will be
7 honest. When we developed this, we had a lot of
8 back and forth about what goes in and what goes
9 out and how that affects the feasibility and
10 likelihood of implementation, and documenting
11 referrals is still very tricky, especially in
12 EHRs. And so we could develop a subsequent
13 measure. We actually have other measures that
14 look at retention in care, but we've also seen
15 that they don't get the uptake.

16 And so it is a thorny issue that gets
17 to the heart of where EHRs are today, and so our
18 emphasis was to get the testing done because in
19 other arenas we have focused on the linkage.
20 Again, referral for us is not enough. When we
21 talk about what happens after care, it's linkage,
22 and linkage for us means they have seen an HIV

1 care specialist. So we have been trying to
2 tackle that through other options.

3 MEMBER TEUTSCH: I'm hearing there's
4 at least 30 percent falling through the cracks
5 because even that 70 percent, they don't
6 necessarily follow through either.

7 MS. VIAL: If you look up to a year
8 out, it's actually much less than 30 percent.
9 Again, our emphasis is increasingly not on just
10 linkage but fast linkage. Linkage, you know,
11 within three months used to be the barometer.
12 Now we're moving to one month. And so the goal
13 under NHAS, I believe, is like to get 70 percent
14 within one month. So it's not just linkage, it's
15 immediate linkage. It's an emphasis on quick
16 linkage.

17 So I believe if I looked at, like, the
18 12-month numbers -- if any of my colleagues are
19 on and have that data in front of them, they're
20 free to chime in here.

21 DR. NISHIMI: If we could just return
22 to the evidence.

1 MEMBER MCKANE: That's kind of where
2 I was going because, I mean, this is all a great
3 discussion, but the measure, I mean, first you
4 have to have screening. I mean, this is like a
5 setup for other measures to come. And, you know,
6 there are, the task force recommendations are for
7 screening of adolescents and adults aged 15 to
8 65, so I think that they've, from what I can
9 read, they've provided, you know, systematic, you
10 know, good evidence that was graded for the
11 importance of screening.

12 The other facets of this is, I mean,
13 I think that discussion comes into play at some
14 point. But I think that the focus for this
15 measure is on the initial screening and the fact
16 that there are gaps, which is the next
17 discussion, so I'll try not to get ahead.

18 DR. NISHIMI: Any other comment on
19 evidence, per se?

20 CO-CHAIR QASEEM: So I just have a
21 couple of comments. First of all, I think it's a
22 very timely measure. I absolutely agree with you

1 the HIV screening has been, we're not still doing
2 as good of a job as we should, considering the
3 evidence that is out there.

4 Not a criticism, I feel like this
5 measure actually doesn't go far. I was a little
6 bit concerned about the 65 as the upper age
7 limit, as well, and there is a lot of new
8 emerging evidence that's questioning 65,
9 especially folks who are living in other living
10 situations. So that's one issue.

11 And then I'm concerned on the lower
12 age limit, the 15 to 18, because that always is a
13 tricky one for, you're not an adult. And my
14 worry is will that be under physician control?
15 Is there any evidence that you have that we can
16 still screen, despite all the issues that are
17 associated with the younger population?

18 And the last comment that I had in
19 terms of, again it's based on the evidence is
20 that I've always, and I know there is no
21 evidence, Abigail, and you probably won't be able
22 to answer that one anyway, but this one-time

1 screening just bothers me a lot because a 55-
2 year-old adult man who was screened 20 years ago
3 would satisfy the criteria for this measure.

4 So it's sort of a general comment, if
5 you have any response. Otherwise, as I said,
6 this is a very timely measure. It's about time.
7 I've been pushing CDC for this for a long time.

8 MS. VIAL: Well, good. Then I'm glad
9 we're responsive eventually. So I will take
10 those in turn for the over 65. I think there is
11 a lot of interest in re-examining that upper
12 bound at this point because of the way the USPSTF
13 guidelines are developed, the way our guidelines
14 are -- I'm not sure we could have a measure that
15 goes beyond the evidence and get good uptake.

16 The other issue is, particularly in
17 the over 65, I'm not sure, although a lot of the
18 studies that were done earlier looking at this
19 are old at this point, but the question is
20 whether it would make sense to do general
21 screening or targeted screening, which gets to
22 what CDC ultimately hopes to bring forward in

1 future years is targeted testing measures based
2 on risk. Those have proven very thorny, as well,
3 because cataloging and documenting risk in
4 electronic health records or administrative data
5 is very difficult. So I would say, at this
6 point, we do have other measures in the works
7 that might address the over 65, at least to some
8 extent, based on risk.

9 For the 15 to 18-year-old population,
10 that is a challenge. We do know that, I want to
11 say there was recent BRFSS data -- and, again,
12 folks on the phone, if I'm mangling this
13 entirely, please jump in -- but I think it was
14 somewhere along the lines of at least 30 to 40
15 percent of sexually-active adolescents between
16 the ages of 15 and 18 had at least been tested
17 once for HIV already. So it's not great, but
18 there are ways to get to improving in that
19 particular population, and we would say that
20 that's a group that we really want to emphasize
21 because a lot of the incidence right now is among
22 younger people, not --- adolescents and young

1 adults, 18 to, say, 24. So that is less a
2 problem with the measure than how CDC tackles
3 implementation working with its partners.

4 Finally, for the one-time ever, this
5 is the hardest part of this measure, both
6 conceptually and in terms of actual
7 implementation. At some point, I think there is
8 probably room now to go back and look again, but
9 the evidence right now, for one-time only, it's
10 very strong on both an individual level and a
11 sort of population cost-effectiveness evaluation
12 level.

13 Again, given the changes recently in
14 treatment guidelines, it's possible that a more
15 frequent, more recurrent screening rate for the
16 general population could now be cost effective,
17 but it hasn't been looked at and, again, the way
18 guidelines development and implementation
19 processes go, it could be several years in the
20 making. So we're trying to push the one that has
21 been accepted as valid.

22 MEMBER HILL: Yes, can I ask if you

1 can elucidate why you selected the age 15 as the
2 lower end when the CDC recommends 13?

3 MS. VIAL: So CDC would say 13. To
4 be honest, because the USPSTF recommendations
5 have more sway, they have more sort of
6 established power -- especially now in law --
7 than the CDC recommendations do. And also
8 because some of the groups that we would want to
9 work with on implementation are a little bit more
10 reticent about endorsing for the 13, 14, and 15
11 than they are for 15 and above. So groups like
12 American Academy of Pediatrics -- or American
13 Pediatrics Association, folks like those, some
14 have been more reticent about that 13 to 15,
15 whereas they've been more open to adopting 15.

16 But, yes, CDC -- had it just been in
17 our power and we had the same cache as USPSTF, we
18 would have gone for 13. But, sadly, we don't, at
19 least according to the health reform law.

20 CO-CHAIR McINERNEY: So one of the
21 problems with testing at 15 to 18 is patient
22 confidentiality. Because so many times, although

1 you and the patient may have confidentiality and
2 the parent is not in the room, etcetera, the
3 insurance claim forms come to the parents and
4 they see HIV testing and say, well, what the heck
5 is that all about? And that can be a big problem
6 for the pediatrician. So I think to get above a
7 certain percentage in that 15 to 18 age range is
8 going to be difficult.

9 MS. VIAL: And I will be honest. CDC
10 has not only our division of HIV/AIDS prevention,
11 but also our division of STD prevention. This is
12 a big issue for testing for STDs and other
13 certain confidential services that kids don't
14 necessarily want their parents to know they're
15 getting. And so we have been working with the
16 Guttmacher Institute and others to sort of
17 examine the issue of EOBs and whether there are
18 ways to structure the way EOBs are handled for
19 certain services in certain vulnerable
20 populations, which, technically, is not just
21 adolescents. It could be wives of abusive
22 husbands or certain other populations. So

1 dependents, in general, are potentially
2 vulnerable when they get certain services, and so
3 looking at the EOB issue is a separate policy
4 issue that we are looking into.

5 MEMBER HARRIS: I'd just like to say
6 that in Tennessee part of the work that I've
7 worked with the Department of Children's Services
8 are with children who are part of the juvenile
9 justice system and they come into this system at
10 12 and 13 and all of them have HIV
11 testing/screening, period.

12 Part of the work that I did with the
13 FQHC -- where I was previously chief medical
14 officer -- the way we handled it was that we had
15 it as, you know, a bundled conversation versus it
16 being separated and teased out. And as a part of
17 the initial paperwork for signing in, there was
18 the notation related to opting out versus us
19 having to have a conversation about opting in.

20 So I'm not sure if there's a way that
21 this could be a part of the measure. But, you
22 know, typically, that was the way that we handled

1 it.

2 MS. VIAL: And those are in keeping
3 with CDC's recommendations in 2006 where we did
4 emphasize that this should be routinized, it
5 should be opt-out, it should be part of general
6 consent. And, really, we see this measure as
7 furthering that because it's sort of
8 standardizing this. HIV screening is like
9 cervical cancer screening, it is like breast
10 cancer screening, it is like any generalized
11 screening. And having a measure that kind of
12 says that that is something that we think
13 physicians should do and be held accountable for
14 is part of moving towards that conversation. But
15 I think there are other implementation issues
16 that we've been working a lot with state health
17 departments and providers on to sort of smooth
18 the process for all groups so that people can get
19 these tests.

20 DR. NISHIMI: Jason?

21 MEMBER SPANGLER: I may have missed
22 this in the paperwork, but do you have a

1 definition of screening in your measure? Because
2 it seems like testing and screening are being
3 used interchangeably, and I'm wondering if the
4 measure should be testing, not screening, because
5 you say in your numerator it's either
6 documentation of a test or evidence of HIV
7 infection, but you also say that HIV infection is
8 often not recognized by physicians. So I'm not
9 sure if I think that the evidence of HIV
10 infection should be part of the numerator unless
11 you have a definition of screening, aside from
12 testing.

13 MS. VIAL: This may be a CDC internal
14 baseball semantics thing. So we have often used
15 screening when we talk about generalized, not
16 dependent on risk, and we use testing internally
17 when we're thinking more about risk-based or
18 diagnostic testing. So I don't think that we
19 would be opposed to making it a testing measure,
20 as opposed to a screening.

21 The other thing, though, is that the
22 USPSTF recommendation states screening. So this

1 sends a signal in terms of we are aligned
2 evidentiary-wise with the USPSTF.

3 MEMBER SPANGLER: So I understand that
4 completely. But then my question would be the
5 second part of that numerator, evidence of HIV
6 infection, how would that be determined? Apart
7 from testing.

8 MS. VIAL: ICD-9, diagnostic codes.
9 I mean, as part of EHR core elements, your
10 diagnoses -- your current diagnoses should be
11 documented in the record. And then also ICD-9s
12 are in there. Or ICD-10 now, but --

13 MEMBER SPANGLER: So you would be okay
14 with an ICD-10 code but no evidence of an HIV
15 test?

16 MS. VIAL: It seems unlikely that a
17 person would be receiving active care for HIV who
18 hasn't received a test. So I think, in that
19 particular case, there would -- having another
20 test for that person -- I mean, this measure
21 already has the potential for over-testing.
22 Let's just put it out there. So in that

1 particular case, the potential that you're doing
2 unnecessary testing really, really skyrockets.

3 MEMBER HARRIS: I guess I just wanted
4 to get further clarity. So when you're saying
5 screening, you're talking about the OraSure,
6 you're talking about just a simple blood test to
7 determine whether or not someone is HIV positive.
8 But then when you're talking about testing for
9 HIV, then you're actually speaking about the
10 actual RNA test for the virus itself, or what
11 exactly are you using for your criteria?

12 MS. VIAL: When we say screening, we
13 mean that the person has received testing
14 according to CDC's 2014 testing algorithm, which
15 is now sort of a standard for the United States.
16 So that would be the initial Ag/Ab test and then
17 an HIV-1/HIV-2 differentiation based on the
18 results of the first screen, and then there's
19 actually a third step, too, depending on how the
20 HIV-1 and the HIV-2 tests go out. So we expect
21 people -- when they're tested or screened, that
22 they're getting the algorithm for the whole test.

1 MEMBER HARRIS: Was that actually
2 listed in this document?

3 MS. VIAL: It is not.

4 MEMBER HARRIS: Okay.

5 CO-CHAIR QASEEM: So, Abigail, can I
6 follow up on what Jason just brought up? I think
7 it's an important issue. So the task force does
8 talk about the testing part. The second part
9 that you have added on, the evidence of HIV
10 infection, am I hearing correctly that you're
11 willing to delete that part from the numerator?
12 Because I'm not aware of any evidence -- and if
13 you're talking about the evidence, I'm not sure
14 if that leads to improved outcomes, depending on
15 what stage that's happening in. All that gets a
16 little complicated. We're talking about
17 screening, which is through testing.

18 MS. VIAL: So the reason we added
19 that in the numerator was because the assumption
20 is if you've been diagnosed with HIV and you're
21 being treated for it, you have ipso facto been
22 tested and diagnosed at some point. So this,

1 again, is getting to the fact that healthcare
2 records are fragmented. And so we wanted -- and,
3 again, it is a one-time only measure. So we
4 included that in there to minimize over-testing.

5 Another option would have been to just
6 exclude them from the denominator. That's
7 another way to handle people who are already
8 diagnosed. The reason we wanted to include them
9 in the numerator was because, at some point, that
10 person got a test, so they met the measure at
11 some point. And so we didn't want to subtract
12 credit for that group.

13 But, you know, you could reconstruct
14 it taking them out of the denominator. We just
15 wanted to acknowledge the fact that a person who
16 has been diagnosed has been tested and so, at
17 some point, met the measure.

18 MEMBER SPANGLER: So you're saying
19 those patients who were tested but might not have
20 been documented that they were tested, but later
21 they had been diagnosed with it somehow, is that
22 -- I'm trying to not let anyone fall through that

1 --

2 MS. VIAL: Yes. I mean, so,
3 basically, again -- because, you know, in an
4 ideal world we would all have our longitudinal
5 records and they would be great. But, you know,
6 a person that was tested for HIV and diagnosed
7 in, say, 1990 and then they've been getting care
8 ever since, the record that this measure is being
9 sort of run against the algorithms, they may have
10 the diagnosis and the documentation of care in
11 their current record. They may not have that
12 test from 1990. But we want to give credit for
13 the fact that that person was tested and the
14 doctor knows that they were tested. So, yes,
15 that's why we included it in there.

16 MEMBER BIALEK: I'd like to follow up
17 on Barry-Lewis's question and the response to the
18 question. It was very helpful having the
19 specifics for the measure noted. From an NQF
20 standpoint, two questions. One is, for all the
21 measures, it would be helpful if we had the
22 specifics, if the developers provide those

1 specifics. And, secondly, if we endorse the
2 measure, can we ask that those specifics be
3 included? Because the measure itself lack that
4 specificity. It's in the spreadsheet? Okay.

5 MS. VIALL: Well -- go ahead.

6 MS. MUNTHALI: So if the specifics are
7 not there, we can ask the developer to update the
8 measure with that information --

9 MS. VIALL: I'm sorry. I lost -- who
10 was the person and what information did I give?

11 MS. MUNTHALI: He's talking about,
12 generally, specifics to clarify --

13 MEMBER BIALEK: What was included in
14 the test? So what --

15 MS. VIALL: Oh, the testing algorithm?
16 Oh, yes, we can easily --

17 MEMBER BIALEK: But Marcel said -- you
18 said that it is in there. I thought you said it
19 wasn't in there, which is why I was bringing that
20 up. I'm so confused.

21 MS. VIALL: So I would say it's not in
22 the measure at this point because CDC's algorithm

1 is supposed to be the standard for testing. We
2 would say that any test would need to, ipso
3 facto, follow the algorithm and laboratories
4 should know that. But could we put that in the
5 sort of detailed specifications for how this is
6 implemented? Certainly.

7 MEMBER SALIVE: Well, I was just going
8 to make the point that, you know, every screening
9 measure has this issue that, you know, there's
10 false positives and false negatives. And so they
11 have, I think, done it properly here, so I have
12 no concerns. But, you know, we'll get to that on
13 other screening measures, as well, that you can't
14 -- yes, you kind of have to translate it because
15 you don't want, you know, you want that next
16 step, it's a natural next step of validating the
17 screening test. So I have no concern.

18 MEMBER TEUTSCH: I want to get back to
19 your point about including the people who already
20 have an HIV diagnosis in the numerator and the
21 denominator. It seems to me that that creates
22 issues with the purpose of the measure because if

1 you're in a place that has high HIV rates you're
2 going to have -- that's going to sort of boost
3 the -- if I went into an HIV clinic, everybody
4 would have HIV, right? And they'd get 100
5 percent when, in fact, they have nobody really,
6 other than people coming in, you know, for
7 screening. But if they're really a treatment
8 clinic they'd have everybody positive and, yet,
9 they don't even do -- they wouldn't be involved
10 with this.

11 So I wonder if there isn't a virtue in
12 actually eliminating it from both the numerator
13 and the denominator so that you're actually
14 looking at -- what we really want to say is, of
15 the people who are out there and don't know they
16 have it, have they been properly tested, in which
17 case you'd get to a different specification.

18 MS. VIAL: So, again, I'm not
19 diametrically opposed to that in any way. The
20 reason we had the numerator broken out that way
21 is so that you could actually look at it. And
22 you will see, also, in the validation testing

1 that we provided you, we did run this in -- one
2 of the CHCs that participated in the testing was
3 a Ryan White Clinic, and so their performance
4 rate is substantially above that of their FQHC
5 brethren.

6 The reason, again, that we did this
7 was because we still consider -- if that provider
8 didn't -- I guess -- let's see, the best way to
9 put this. We still wanted to give people credit
10 for knowing the status of their patients, whether
11 they knew that status because they already knew
12 that this person was coming to them for treatment
13 for HIV or they knew it because they had run the
14 test. Either way, that provider has done the
15 right thing. They have ascertained the status of
16 their patient and know that that person has been
17 tested at least once.

18 It was mainly a philosophical thing.
19 We had a group that helped us develop this
20 measure, and it was kind of like do we want to
21 "see" the people that have been diagnosed with
22 HIV in this measure or not, and the group

1 consensus ultimately came in that, yes, we would
2 like to see them in there, but we've constructed
3 it in a modular fashion so that you could
4 differentiate is the high performance because it
5 is a Ryan White Clinic, or is the performance
6 driven by the fact that this is a primary care
7 clinic that is ascertaining the status of most of
8 its patients? So that was why we actually have
9 the three numerators. But, again, it was a
10 philosophical choice.

11 CO-CHAIR QASEEM: Sorry. Last comment
12 and then we'll move on to the next topic.

13 MEMBER MCKANE: I agree. I see
14 there's a benefit in knowing, you know, the
15 totality of HIV infection, but I like that you
16 can parse this out so that we can answer the
17 questions that Steve raised.

18 CO-CHAIR QASEEM: There you go. It's
19 on. The other light was on. Sorry. So we're
20 going to, we will have to vote on this measure
21 eventually, once we're done with the discussion,
22 based on what we have been presented in front of

1 us. And if we do want the numerator statement to
2 change, then we will have to go back to CDC, and
3 then CDC will have to come back with a modified
4 version. So we'll get to it.

5 So moving on from evidence to gap?

6 Oh, sorry.

7 DR. NISHIMI: We need to vote on it.

8 CO-CHAIR QASEEM: Oh, we just keep on
9 voting on each section?

10 DR. NISHIMI: Yes.

11 CO-CHAIR QASEEM: Oh, okay. All
12 right. So in that case, what we have in front of
13 us is what we have in front of us. So we cannot
14 really modify it, so today what we need to do is
15 decide whether we're comfortable with what we're
16 being asked to vote on. So let's vote on the
17 evidence.

18 MS. CRAWFORD: Voting on Measure 3067,
19 evidence. One for high; two, moderate; three,
20 low; four, insufficient, and we need 15 votes,
21 please. We have 10 high, 5 moderate, 0 low, 0
22 insufficient. 67 percent high, 33 percent

1 moderate.

2 DR. NISHIMI: So I think we can move
3 to vote on gap because we've discussed that.

4 MS. CRAWFORD: Voting is open for
5 performance gap on measure number 3067. One,
6 high; two, moderate; three, low; four,
7 insufficient. We have 12 high, 3 moderate. 80
8 percent high, 20 percent moderate.

9 DR. NISHIMI: Okay. Now we move to
10 the specifications and the reliability, and we've
11 had some discussion about that already, about the
12 numerator. And there was also discussion in the
13 staff evaluation about the denominator, lack of
14 denominator testing. So if the Committee could
15 discuss that, and then we'll be ready to -- and I
16 guess Patricia and Steve.

17 MEMBER MCKANE: The developers did do
18 reliability testing. It was data element. And
19 with the NQF assessment that followed the
20 specifications, you know, they landed
21 insufficient. And when I was reviewing this,
22 some of the issues that I saw, and also there's

1 some comments in here that are very good, that
2 they didn't test -- they tested the numerator
3 only and not the denominator, although that may
4 or may not be an issue. And the study was
5 limited to the Chicago area. There's no
6 geographic variation at all. This time, it is
7 the Midwest, so go. And so there might be some
8 concerns about generalizability across the
9 country, but there were different types of health
10 centers, which that's excellent.

11 But I thought that, you know, I wasn't
12 really clear on the reliability testing, and
13 there were some questions when I was looking at
14 this. It's probably okay, but empirical evidence
15 is very limited. And so I don't know if other
16 committee members have comments, you know, that
17 want to get in on this or not. I do think
18 there's some questions about the reliability
19 testing.

20 MEMBER TEUTSCH: Yes. So to put a
21 little finer point on that, so there's a testing
22 of the elements in the EHR that I, frankly, don't

1 understand but apparently pass muster by those
2 who do. But I actually didn't, would have liked
3 to see a little bit more explicit description of
4 things like opting out, how that was handled and
5 whether that's actually in the record. I think
6 you related to the problem of how do you really
7 know if somebody had a test 40 years ago, and it
8 sounds like you don't want self-report; you want
9 to have more documentation, which, in our current
10 healthcare system and our population mobility, is
11 almost impossible. So it struck me that -- and
12 it's really hard to check the reliability of
13 that.

14 So it struck me that there were some
15 significant reliability issues here, and, you
16 know, I was struck also by the fact that this was
17 sort of in one, in Chicago largely, FQHC-oriented
18 population. I don't know if that's good or bad,
19 but it did strike me as relatively limited. So
20 those were some of the things that concern me.

21 MS. VIAL: So can I take this? Okay.
22 So let's go through those in turn. The measure,

1 there's no handling of opting out because opting
2 out is not considered in this measure. It's just
3 like when you talked about cervical cancer
4 screening yesterday. Our feeling is a person may
5 refuse a test at some point for various reasons,
6 but this is recommended, and so physicians should
7 try to understand why a person is refusing a test
8 and then work to address those issues. So we do
9 not make an exclusion exception for opting out,
10 so that's not something that -- it would be very
11 hard to document in the EHR anyway because that's
12 not a standardized national sort of data element.
13 So it would make the measure very hard in terms
14 of feasibility, but it also, philosophically, is
15 not in keeping with our expectations of
16 providers, vis-a-vis screening for this service.

17 Let's see. I will mention the
18 reliability and validity, it was a little
19 confusing, honestly, for us, too. We had to work
20 with NQF staff multiple times to understand it.
21 So because we did data element testing, they
22 didn't ask us to fill out the reliability

1 section, so some of these measures, some of these
2 issues may not have been addressed as well in
3 there because we just moved to the validity
4 section.

5 So that handles opt-out for the one-
6 time only. That is a large issue, and it came
7 into, you know, CDC has vacillated a while on
8 developing this measure because of our concerns
9 about over-testing. When the group that
10 developed this measure sort of met, we did -- and
11 I will be honest, we never documented them, but
12 we sort of did back-of-the-envelope calculations
13 where we looked at what are the costs, individual
14 and for the health system, of late diagnosis of
15 people not knowing their status, and how do those
16 pan out with what we think might be the missing
17 data in the record, in terms of the potential for
18 repeat testing. And what we ultimately came to
19 the conclusion of is that the costs of the repeat
20 testing are not, they're not as great as the
21 costs for the individual in a health system of
22 late diagnosis or missing a diagnosis.

1 The other thing that we would say is
2 if a provider does not know the status of his or
3 her patient and cannot find documentation, he
4 probably should test again. And there was a lot
5 of philosophical debate about self-report, but
6 there is evidence out there that a lot of people
7 just figure I've had a blood test by my provider
8 in the past, and surely he or she must have
9 already tested me for HIV, so that's why we
10 didn't go with self-report as good enough because
11 of that issue.

12 So, yes, there is a potential for
13 over-testing here. Again, weighing the costs and
14 benefits, we thought that the value of getting
15 everyone tested outweighed the potential risk of
16 some over-testing.

17 CO-CHAIR QASEEM: Any other comments
18 on reliability or validity? Because I do want to
19 keep us moving. We're a little behind on our
20 agenda.

21 MS. VIAL: Can I address the Chicago
22 thing?

1 CO-CHAIR QASEEM: Okay. Summarize
2 your comments, please.

3 MS. VIAL: Very quickly, CDC has an
4 interagency agreement with CMS. We are going to
5 do additional testing for this measure. We
6 intended to do additional geographic testing and
7 also in different health systems.

8 When I brought this measure forward to
9 the NQF staff, I asked should this be a time-
10 limited endorsement or sort of a trial use, like
11 you've done for the Hep C measures yesterday,
12 because we do intend to do additional testing, or
13 is the testing we've already done good enough?
14 And they said the testing you've done already is
15 more than most measures come forward with, so,
16 even though it's geographically restricted, so
17 please bring it forward for full endorsement and
18 then just note that, yes, we have given money to
19 CMS to develop to do additional testing for this
20 particular measure.

21 CO-CHAIR QASEEM: So Elisa and then
22 Arjun, last comment. We're going to vote then.

1 MEMBER VENKATESH: Thanks. So I'm not
2 particularly, I guess, as concerned about the
3 opt-in/opt-out. The way I think of this is this:
4 there is insufficient data on reliability. I
5 think that is okay because this is specified as
6 an eMeasure. There's not going to be a lot of
7 available test beds or things to get a lot of
8 reliability testing done, and so we go down this
9 path where we go to then look at the score
10 element validity. The only one that's concerning
11 to me there is this question of are we, can we
12 validly capture previous testing that may not
13 have happened within that EHR, previously done,
14 things along those lines.

15 I think you guys have an adequate
16 answer as to why you think you understand the
17 risk of over-testing and that you've thought
18 about that, done this back-of-the-envelope
19 calculation, and so it's still valid to do it
20 this way.

21 My primary concern on this measure is
22 what we call threats to validity section, which

1 is at the end of this. And I don't know if this
2 is going to fit into this vote or the next vote.
3 But the question of a threat to validity is, is
4 the measure score show meaningful differences in
5 performance, is the question. And the reason
6 that's so important is because you guys are
7 working with CMS on this measure and indicate in
8 use that it's for accountability programs. And
9 so you want to use it to compare two physicians,
10 two facilities, potentially use it in MIPS, as
11 you have in your application. And that means
12 that I have to be able to compare two scores
13 directly the way they would get used.

14 And so the problem with the measure is
15 this numerator issue. If you do not exclude
16 those with HIV, then somebody's score of 40
17 percent cannot be compared to somebody else's
18 score of 20 percent for accountability purposes.
19 And that is not a meaningful difference in
20 quality. That is just potentially a meaningful
21 difference in HIV prevalence. And that, to me,
22 is a massive threat to validity.

1 And so I think, as it is currently
2 specified, if it is going to say that the
3 numerator is either HIV status or that you got
4 screened, then it does not actually reflect
5 meaningful difference in quality between two,
6 whatever your level of measurement is. And that,
7 to me, means low for a threat to validity, which
8 if we, since we don't have reliability testing,
9 we have to vote on validity, I guess I would vote
10 low for that reason.

11 CO-CHAIR QASEEM: Okay. So let's
12 vote.

13 MS. CRAWFORD: Voting is open on
14 Measure 3067, reliability. One is high; two,
15 moderate; three, low; four, insufficient. We
16 have 0 high, 5 moderate, 5 low, 5 insufficient.

17 MS. MUNTHALI: Well, so we just wanted
18 to let you know. So this measure fails on
19 reliability because less than 41 percent have
20 voted high or moderate. So --

21 CO-CHAIR QASEEM: So, Abigail, you
22 have probably heard enough comments from the

1 Committee. I don't think it's going to be too
2 difficult to fix this measure. The Committee is
3 generally supportive of it with some issues with
4 the numerators, denominators, and all that you
5 already heard. So I think it would be very
6 helpful if you could bring it back again for
7 reconsideration.

8 Okay. Moving right along, Measure
9 3086. No, 3087, sorry. No, I do have it right.
10 3086. It's also a CDC measure.

11 MS. VIALL: Hi again.

12 CO-CHAIR QASEEM: Do you mind if you
13 can just keep your introduction to as short as
14 possible, please?

15 MS. VIALL: Yes, yes.

16 CO-CHAIR QASEEM: Thanks.

17 MS. VIALL: So, in essence, this
18 measure is intended to look at state performance
19 with respect to achieving viral load suppression
20 among people living with HIV. Viral load
21 suppression is a good barometer of whether we are
22 meeting the both individual needs of people

1 living with HIV, since viral suppression is a
2 good indicator of whether they are sort of
3 healthy and more likely to live longer lives.
4 It's also a huge indicator of transmission, or
5 ability to transmit I guess is more the case.

6 So this measure addresses both an
7 important public health aspect from the
8 individual patient perspective and from the
9 public health perspective. It is a complement to
10 an individual or provider, individual
11 provider/clinic-level measure that HRSA already
12 has NQF-endorsed. So getting to our previous
13 discussions about the desirability of having sort
14 of community-level and provider-level measures,
15 this measure is intended to complement and sort
16 of extend the existing measure, or the existing
17 NQF stable around HIV measures.

18 CO-CHAIR QASEEM: Thank you. Steve,
19 Emilio, any comments? Any general comments from
20 the committee?

21 MEMBER HILL: One question. This
22 seems to start at age 13 instead of 15.

1 CO-CHAIR McINERNY: Yes.

2 MS. VIAL: That's because we own
3 this. This is actually, it's based on our
4 surveillance systems, and most of our
5 surveillance systems, we look at pediatric
6 HIV/AIDS separate from adult.

7 CO-CHAIR QASEEM: So can I ask just a
8 general question? Maybe I didn't really
9 understand this. This is just pretty much,
10 you're just collecting data, so why can't you
11 just get this state-level data? Why does this
12 need to be a measure? What's the point behind
13 this measure? I'm not getting it. This is
14 statistics, essentially.

15 MS. VIAL: What do you mean, what's
16 --

17 CO-CHAIR QASEEM: You're going to get
18 state-level data. Well, you can just collect
19 this data. Why does this need to be a
20 performance measure?

21 MS. VIAL: So that is, that was
22 actually a question that we all asked ourselves

1 internally. I mean, honestly, CDC can keep doing
2 this measure. NQF has expressed interest, and,
3 as far as we understand from the IOM, there's
4 interest in starting to consider measures that
5 are not just at the provider level, but the idea
6 of measuring quality sort of across strata,
7 strata of performance, so the individual provider
8 level, the clinic level, the plan level, the
9 community level.

10 So we're a little unclear on where
11 this measurement area is going, but we thought we
12 had a good measure that sort of fits what is
13 happening in this space, and we put it forward
14 because we understood that the call of this
15 particular committee was community health
16 measures, and we think this is an important one.
17 It is the sort of signature one being tracked by
18 the National HIV/AIDS Strategy. But, yes, we can
19 do this whether you endorse it or not.

20 CO-CHAIR QASEEM: Yes, because it's a
21 performance measure, so I'm trying to figure out
22 what are we going to be -- who is going to be

1 improving what with this. As I said, it's a very
2 crude way to say it. I look at it as statistics.

3 MS. VIAL: States are being tracked
4 on this already, and we are pushing performance
5 increases. This is -- state performance on this
6 particular measure is, again, one of the number
7 one priorities in NHAS. So we are tracking this,
8 and we do expect states to improve, and they have
9 already shown trends towards improvement.

10 MEMBER VENKATESH: I guess the state-
11 level use I could think of is state Medicaid
12 agencies or states that apply for SIM models to
13 CMS have to propose quality measures for
14 different waivers and for different programs.
15 And so I imagine this could be a measure they
16 would choose as an intermediate outcome or an
17 outcome measure of state-level efforts in those
18 programs.

19 MEMBER CARRILLO: I agree. I mean, I
20 think that there's value in states competing with
21 each other. I mean, it's a NQF measure. It's
22 not just a, you know, statistic in a book. So I

1 think that it makes sense for us to move forward
2 with this.

3 CO-CHAIR QASEEM: So let's go through
4 the process of voting, unless there is any other
5 further discussion on this measure. I'm not
6 seeing anything, so evidence.

7 MS. CRAWFORD: Sure. Voting is open
8 on Measure 3086 on evidence. One, high; two,
9 moderate; three, low; four, insufficient. All
10 votes are in. 5 high, 10 moderate, 0 low, 0
11 insufficient. 33 percent high, 67 percent
12 moderate.

13 CO-CHAIR QASEEM: So we're going to go
14 with gap now. Performance gap.

15 DR. NISHIMI: Any discussion on gap?
16 I think someone raised the question about why it
17 was only 29 or however many. 27 states.

18 MS. VIAL: It's now 33 in this year's
19 report.

20 CO-CHAIR QASEEM: Well, I have a
21 question. Performance gap for who? Who are we
22 measuring here?

1 MS. VIALL: States.

2 CO-CHAIR QASEEM: Do state-level
3 performance measures fall under the purview of
4 NQF, something along the lines they do?

5 MS. VIALL: Yes.

6 CO-CHAIR QASEEM: I just wanted to
7 make sure. Maybe I missed that.

8 MEMBER TEUTSCH: So, I mean, there are
9 two gaps, right? I mean, one is the number of
10 states that are doing it, but it's also that
11 there's a big gap in viral suppression.

12 MS. VIALL: Yes.

13 MEMBER TEUTSCH: All right. And so
14 there should be some accountabilities for --

15 MS. VIALL: Yes.

16 MEMBER TEUTSCH: -- closing both those
17 gaps.

18 MS. VIALL: That is CDC's position.
19 And, you know, what we would say is, you know,
20 again, in the National HIV/AIDS Strategy, the
21 goal is that it's 80 percent, and no state, in my
22 memory, has yet met that.

1 MEMBER MCKANE: I have a question.
2 There's only a handful of states that have been
3 doing this. Are there plans to expand this to
4 all the states? And then is there data available
5 at, like, a sub-state level or in small
6 geographies? Because we certainly have lived
7 that experience of needing to know something that
8 may look fine at the state level is not good in
9 certain areas of our state.

10 MS. VIAL: So I would say it's more
11 than a handful. It's over half, 33 states out of
12 50. Well, and D.C., so let's call it 51. And,
13 yes, there are, states are moving in this
14 direction. This is a huge push for CDC and for
15 states in general to be able to measure viral
16 load suppression among the residents. But for
17 most states, this begins with passing laws,
18 passing laws to make sure that viral load and CD4
19 count data, all values, all test values are
20 reported to the state surveillance program.
21 That's the first step.

22 And states have been rapidly pushing

1 for changes in their laws. There are very few
2 states at this point who don't have laws in place
3 that mandate reporting. So that's the first
4 push.

5 And then there's a push for actually
6 setting the processes up and making sure that
7 you're getting all the reports from the labs and
8 making sure the data are high quality. CDC does
9 not report until states have not only gotten the
10 laws in place but then have also done the quality
11 sort of assurance. And so that's why it's 33
12 states with mature systems. There are many more
13 states that are getting these data and could
14 probably calculate it. We just don't have as
15 much, I don't want to say faith, but we're still
16 a little bit less certain about reporting this.
17 Those states can calculate and use it for their
18 own purposes, but for a national report, we're
19 not quite putting them out yet.

20 CO-CHAIR QASEEM: Ron, do you have a
21 comment?

22 MEMBER BIALEK: Yes. You know, I

1 think this measure, we're talking about states,
2 and I think we're talking far beyond state health
3 departments. We're really talking about the
4 health system, talking about policy. We're
5 talking about really the role of the healthcare
6 providers even in policy development and policy
7 advocacy, et cetera. And I think that's part of
8 what we're supposed to be doing as a committee,
9 dealing with population health measures that are
10 outside of the clinical, that may have a policy
11 component to it.

12 And so I just want to make sure that
13 we don't get wrapped around the clinical pieces
14 on this because it is broader than that. It does
15 require the policy intervention and the
16 responsibility of the health system providers in
17 a state to engage in that policy development.

18 CO-CHAIR QASEEM: Any other -- okay.
19 So I'm not seeing any other comments. So let's
20 vote on it, please.

21 MS. CRAWFORD: Voting on Measure 3086,
22 performance gap. One, high; two, moderate;

1 three, low; four, insufficient. 10 high, 5
2 moderate, 0 low, 0 insufficient. 67 percent
3 high, 33 percent moderate.

4 CO-CHAIR QASEEM: So let's take on
5 scientific acceptability. Can we take
6 reliability and validity together, please? Any
7 comments? Okay. Seeing no comments, let's vote.
8 Oh, there is a comment. Steve?

9 MEMBER TEUTSCH: Well, I'm worried
10 about a couple of things here. One is the system
11 is actually pretty slow.

12 MS. VIAL: It's getting faster.

13 MEMBER TEUTSCH: It's getting faster.
14 Having coordinated surveillance at CDC, I
15 understand the problem. But it is a problem
16 because it lags by two to three years, actually,
17 in some states, which is a long time when you're
18 trying to do quality improvement.

19 Along those lines, I guess I'd make a
20 suggestion that there be interim reporting
21 because that would then lead people to get their
22 act together quicker and get the data to you and

1 get it out faster, and so it can be more
2 reliable. More usable, not necessarily more
3 reliable.

4 CO-CHAIR QASEEM: Matt, you had a
5 comment?

6 MEMBER STIEFEL: Well, we should be,
7 the staff rated this as insufficient, and I think
8 it's worth a little bit of discussion and a
9 question for the staff about the algorithmic
10 insufficient rating because, otherwise, we may
11 fall into exactly the same issue as the previous
12 measure.

13 DR. NISHIMI: So they didn't conduct
14 empirical testing at the data element level,
15 which could have been used for the reliability
16 testing. For the reliability testing, they cited
17 the systems and quality control for their data
18 that, you know, the data inputs, if you will.
19 And under the NQF algorithm, that becomes an
20 insufficient rating.

21 The committee can obviously decide
22 that, you know, based on its experience and

1 knowledge, the inputs and then follow up into CDC
2 there's a continuous stream or at least mostly
3 continuous stream because there is some places
4 that enter it manually. And so they could rate
5 it otherwise, but that's what led to the staff's
6 insufficient rating.

7 MS. VIAL: Am I allowed to respond to
8 that? And if my colleague, Irene Hall, is on the
9 phone, I might also defer to her. But I think I
10 will be honest that algorithms that we had to
11 sort of walk through to submit this measure,
12 they're very well suited for clinical quality
13 measures. Whether they work for a measure that's
14 based on public health surveillance systems or
15 whether the application process is optimized for
16 these kinds of measures, I think CDC would say it
17 may not be. And so the algorithm we don't feel
18 fully reflects the reliability and validity of
19 our surveillance systems.

20 Anecdotally, I can say that we have an
21 affinity group that we're working on with CMS and
22 HRSA where state Medicaid programs are actually

1 clamoring to use the surveillance system viral
2 load data to evaluate the quality of their
3 Medicaid programs because they don't have access
4 to test results, and we do.

5 So within states, there is a general
6 feeling that the systems are incredibly reliable
7 and valid. And where they tend to err, it's
8 often a bias in the downward direction. So we're
9 certainly not inflating anybody's performance
10 with this. It's a conservative bias across the
11 surveillance system, and improving that is
12 something that states are doing iteratively
13 through data to care sorts of activities, where
14 they're actually using their surveillance systems
15 to reach out to people to verify they're in care
16 and, if not, they're looking at how do we improve
17 the data coming into our systems, how do we
18 improve the strength and validity of our systems.

19 So I would say that these are
20 continuously-evolving systems, and we continue to
21 put a heavy investment into improving their
22 reliability and validity.

1 And, Irene, are you on the phone?

2 DR. HALL: Yes, I'm here.

3 MS. VIAL: Do you want to address
4 sort of the fit of the reliability and validity
5 algorithm to our systems?

6 DR. HALL: Yes. Basically, it's less
7 that it's a faith in the process where we think
8 that because the data are electronically reported
9 and then matched and uploaded, they should
10 reflect the actual values. And I agree with the
11 fact, the assessment that it would be a downward
12 bias because our biggest concern usually is that
13 we get all data, all tests completely reported.
14 But we don't have any evidence of any particular
15 bias in terms of it being, the completeness being
16 a bias. It's just a matter of states
17 implementing complete laboratory reporting.

18 DR. NISHIMI: I just want to make one
19 comment before we go to Amir. I mean, not Amir,
20 Arjun and then Steve. We have had other measures
21 come through NQF based on CDC surveillance. You
22 looked at one yesterday coming through the NHSN

1 system on the healthcare vaccination for
2 personnel. So I just wanted to push back a
3 little bit on the notion that the NQF algorithm
4 and criteria don't fit surveillance systems
5 because we have that measure and other measures.

6 During the TA, we recommended them
7 looking at perhaps state audit data, if they were
8 able to get that, so if some states can show that
9 their inputs, you know, are reliable and valid,
10 then we don't need to, you know, necessarily show
11 the whole system. Obviously, that's preferred,
12 but that would have been quantitative evidence
13 for the committee. But based on our algorithm,
14 merely citing state law or indicating quality
15 control and quality monitoring isn't sufficient.

16 So I'll go to Arjun and then Steve,
17 and then I thought I saw another hand.

18 MEMBER VENKATESH: I think one of your
19 comments sort of gets at what I was thinking,
20 which is, this is challenging, right, because the
21 data source that they essentially had is about as
22 close to the gold standard that we would use for

1 some other measure. And so if somebody wanted to
2 make an electronic clinical quality measure of
3 viral load suppression to be used at a facility,
4 we'd say, okay, how does this compare to some
5 gold standard. That gold standard would be
6 something that is collected and structured in a
7 way, and often that would be this.

8 So the only thing I can think of, if
9 we try to put this in a format of an NQF measure
10 for something like this, is to say, okay, the
11 underlying gold standard for this is probably
12 some sort of audit that I'm sure has been done
13 where you could simply just say, yes, at these
14 many sites, we looked at 10 charts, 20 charts, 30
15 charts, and I'm sure 95-100 percent of the time
16 the transcription of the number, which was that
17 viral load locally into the system, was correct.

18 And my guess is that this has been,
19 this has been up and running for a while.
20 There's a large audit process behind this. I
21 think I can live with that and say that I
22 probably trust that that's right and that these

1 are valid. But I guess in an ideal world, if we
2 wanted to make it fit the form, that would be the
3 data that would say, hey, it fits the form.

4 MS. VIAL: And I would say we
5 understand that. And, again, it's also the
6 balance, we are constantly struggling with the
7 states will routinely come back and say you're
8 asking for too much. So there is, we have to
9 balance that fine line of what we look at and
10 what we take their self-certification on.

11 Irene, I think you can speak to this,
12 but I do think we kind of say you are going to do
13 these quality improvement activities and certify
14 that you've met these. And from a federal level,
15 since we're basically doing quality assurance
16 several strata down, we have to accept that
17 that's good enough.

18 Irene, do you want to talk about that
19 a little bit more?

20 DR. HALL: Yes, I'd like to say two
21 things. One is that lab reporting is monitored,
22 and we provide states with quality measures on

1 how to monitor their lab reporting in terms of
2 volume.

3 The other piece about audits,
4 generally we ask states to do re-abstracting
5 studies, but, in this case, a person could go to
6 multiple facilities and it's very hard to find
7 all the multiple facilities, while, when you have
8 complete laboratory reporting, you will get those
9 data from wherever the patient goes.

10 We do have another system. It's
11 called the Medical Monitoring Project, which is
12 funded in select jurisdictions. But since they
13 are now also sampling from case surveillance, we
14 will get some information at least for those
15 select jurisdictions to see whether we can make
16 any assurances about completeness.

17 MEMBER TEUTSCH: So, again, full
18 disclosure, I'm retired from CDC.

19 MS. VIAL: I know. I recognized your
20 name. I think we have an award named after you.

21 MEMBER TEUTSCH: And a surveillance
22 book. So I think what I wanted to say here was

1 that CDC actually has a formal process of
2 evaluating surveillance systems, and they include
3 many of the same kind of criteria that we talk
4 about here, but they're oriented in a different
5 way. And the goal of those evaluations is do
6 these surveillance systems provide information
7 that's useful and can drive action? And I would
8 suggest to NQF that, as we look at some of these
9 measures that come out of those, that we begin to
10 look at the guidance that comes out of those
11 evaluation standards which get at many of the
12 issues I think that we actually care about
13 because the point is that they should be useful
14 at some level of action, in this case the state,
15 right? And we know that, in many cases,
16 surveillance systems have a significant amount of
17 error. So I told you a Salmonella surveillance
18 probably gets two percent of the Salmonella
19 cases. That doesn't mean it's not usable, but
20 there's a certain constancy in it, and you can
21 use it. Obviously, HIV is much better than that.

22 But I would suggest that we have some

1 criteria, CDC uses them, and that we look at
2 them. And I don't know specifically whether HIV
3 has done them, and they probably have. There's
4 been so much attention, you probably meet all the
5 criteria anyway. But there are some things that
6 we could look at that I think would help us and
7 get us out of the clinical care conundrum of
8 holding these metrics, to that kind of standard,
9 public health standards.

10 MS. CRAWFORD: Voting is open for
11 Measure 3086 on reliability. One is high; two,
12 moderate; three, low; four, insufficient. And
13 one more vote. 0 high, 7 moderate, 5 low, 3
14 insufficient. We're at 47 percent moderate, 33
15 percent low, 20 percent insufficient.

16 MS. MUNTHALI: So consensus was not
17 reached, so we'll continue and hopefully resolve
18 this at the post-comment call. So validity, I
19 think we're ready.

20 MS. CRAWFORD: Voting is open for
21 Measure Number 3086, validity. One, high; two,
22 moderate; three, low; four, insufficient. We

1 have 0 high, 9 moderate, 3 low, 3 insufficient.
2 60 percent moderate, 20 percent low, 20 percent
3 insufficient.

4 MS. MUNTHALI: So we're right at the
5 margin. If we just had one percentage point more
6 we would have been able to pass it, but consensus
7 is not reached on this criterion, as well. We
8 will continue to feasibility.

9 CO-CHAIR QASEEM: Any questions or
10 discussion on feasibility? It's also rated
11 insufficient by staff, so do you want to comment
12 on it, or anyone?

13 DR. NISHIMI: The insufficient rating
14 really was derived from the fact that only 27
15 states or now 33 states and the District of
16 Columbia. So as a state-level measure, we didn't
17 have all states, so feasibility was, at some
18 level, insufficient, and trying to endorse a
19 measure for accountability. But, obviously, the
20 committee can feel that it's still feasible and
21 usable.

22 MEMBER VENKATESH: I would think this

1 is highly feasible. There's plenty of measures
2 we endorse that cannot be used or implemented by
3 everybody who meets the level of measurement.
4 There's a lot of hospital measures where many
5 hospitals it's infeasible, where some it is. And
6 so, to me, it's been up, it's running, it's
7 working. I think it's feasible.

8 MS. VIAL: Can I respond to that? So
9 just a quick note. We rapidly expect this to be
10 in the 40s within a year or two.

11 The other thing is that CDC actually
12 sees a state that cannot report on this. That
13 is, in and of itself, a commentary on their sort
14 of, their performance. States that have no
15 results are not following what CDC recommends,
16 which is that this is sort of the standard for
17 HIV surveillance at this point.

18 So when we do our state progress
19 reports, not having this value is actually
20 something that has incentivized a number of
21 states to really look at their laws and try to
22 stand up these systems. So a lot of states

1 actually see the gap in performance that not
2 being able to report on this measure represents
3 as itself very informative.

4 CO-CHAIR QASEEM: Any further
5 discussion? Let's vote, please.

6 MS. CRAWFORD: Vote on Measure 3086,
7 feasibility. One, high; two, moderate; three,
8 low; four, insufficient. One more vote. We have
9 5 high, 8 moderate, 2 low, 0 insufficient. 33
10 percent high, 53 percent moderate, 13 percent
11 low, 0 percent insufficient.

12 CO-CHAIR QASEEM: So now usability and
13 use, the final one. Any comments or discussion?
14 Any comments from staff? Let's vote.

15 MS. CRAWFORD: Voting on Measure 3086,
16 usability and use. One, high; two, moderate;
17 three, low; four, insufficient information.
18 Okay. Our results: 4 high, 10 moderate, 1 low,
19 zero insufficient. 27 percent high, 67 percent
20 moderate, 7 percent low.

21 DR. NISHIMI: Okay. We won't vote on
22 overall suitability for endorsement because you

1 had -- two of the must-pass criteria were
2 consensus not reached, so this will come back
3 after the comment period to the Committee, and
4 then you'll vote on overall suitability for
5 endorsement once those comments have been
6 received.

7 MS. VIAL: Do I get to exit this seat
8 now?

9 DR. NISHIMI: Yes, you do.

10 MS. VIAL: It's a little bit
11 daunting.

12 CO-CHAIR QASEEM: Thanks so much,
13 Abigail, for coming. How about we take a quick
14 break, folks? How about we -- is ten minutes
15 enough? I think ten minutes is too long, right?
16 So 11:15 let's just get back. Thanks.

17 (Whereupon, the above-entitled matter
18 went off the record at 11:04 a.m. and resumed at
19 11:16 a.m.)

20 CO-CHAIR QASEEM: All right. So the
21 next ones that we have on the agenda are the
22 malnutrition measures. And I was just actually

1 talking to Arjun, and he has a valid point. We
2 just need to switch the sequence around. I think
3 we need to probably discuss screening, following
4 by diagnosis, and then it is the same measure, or
5 is it going to make a difference?

6 DR. NISHIMI: We have to first do this
7 one.

8 CO-CHAIR QASEEM: We have to do that
9 one, first?

10 DR. NISHIMI: Oh, wait.

11 CO-CHAIR QASEEM: It is the same
12 people or no?

13 DR. NISHIMI: No.

14 CO-CHAIR QASEEM: It is the same
15 people. It is the Academy of Nutrition &
16 Dietetics.

17 DR. NISHIMI: Yes, that's why we did
18 it. We put this --

19 CO-CHAIR QASEEM: Okay, so that is the
20 issue. All right. Well, will you be okay with
21 that? It says there is an issue with
22 simplification -- simple measures involving

1 discussion.

2 DR. NISHIMI: Yes, that is why -- that
3 is one of the reasons we did it that way.

4 CO-CHAIR QASEEM: So, let's stick with
5 the sequence, and let me welcome our two guests.
6 Do you mind introducing yourself, please?

7 MS. MCCAULEY: Good morning, and thank
8 you for having us. My name is Sharon McCauley,
9 and I am Senior Director of Quality Management at
10 the Academy of Nutrition & Dietetics. And the
11 Academy, just to give you a quick overview, is
12 our world's largest organization of food and
13 nutrition professionals, and we represent over
14 100,000 credentialed nutrition and dietetics
15 practitioners. And we do strive to improve our
16 nation's health through advancing the profession
17 of dietetics, through research, education, and
18 advocacy.

19 Our organization is part of a multi-
20 stakeholder initiative that is focused on
21 addressing malnutrition, which is a leading cause
22 of morbidity and mortality among older adults.

1 As many as 20 percent to 50 percent of our
2 patients are at risk for malnutrition or are
3 malnourished at any time in a hospital admission.
4 Patients malnourished during their hospital stay
5 have a greater risk of complications,
6 readmissions, length of stay, all outcomes
7 associated with increased healthcare costs.

8 Today, I am representing the measure
9 steward of these four measures, and they are very
10 focused on, of course, malnutrition and I am
11 joined with Dana Buelsing, our Manager of Quality
12 Standards and our Chief Science Officer, Dr.
13 Alison Steiber, is on the telephone line.

14 Additionally, our measure developer,
15 our partner, Avalere Health is with us. And
16 today we have Joe Lynch, Director, and Angel
17 Valladares, who is a manager, and they are on the
18 Avalere's Evidence, Translation, and
19 Implementation Practice Team.

20 The Academy worked in partnership with
21 Avalere Health to develop this set of four
22 electronic clinical quality measures or

1 eMeasures. We also have hybrid eMeasures, and we
2 addressed the recommended care process for
3 malnutrition. And we appreciate the opportunity
4 to present for your consideration the four
5 quality measures aligned with the evidence-based
6 nutrition care process.

7 These measures were developed through
8 multi-stakeholder consensus fostered from two
9 national dialogues. We had a dialogue session
10 back in November of 2013, as well as September of
11 2014, and they included representative from CMS,
12 ONC, health plans, health systems, as well as
13 providers and patients. And what we did was we
14 prioritized addressing malnutrition to reduce
15 risk of adverse outcomes.

16 The emphasis is particularly on the
17 hospitalized elderly patients, and they are,
18 again, showing evidence demonstrating a rate of
19 malnutrition as high 38.7 percent. The testing
20 and development of these measures represents the
21 first step in the National Quality Improvement
22 Initiative for Malnutrition, focusing on

1 forthcoming broad dissemination from measure
2 adoption and implementation.

3 These four measures address key
4 components of the recommended malnutrition
5 clinical workflow. And this is how we conduct it
6 in the hospitals. It focuses on the first four
7 of a six-step process, beginning with screening
8 of patients upon admission, then completing a
9 nutrition assessment for those who were found to
10 be at-risk, and finally, the development and
11 implementation of a nutrition care plan for
12 patients properly diagnosed with malnutrition.

13 To reach such a goal, our
14 organizations have developed these individual
15 hospital-level measures focused on malnutrition,
16 and, again, we align them with a multi-step
17 process to address malnutrition. These measures
18 address a need to encourage proper management of
19 the elderly patient population in the hospital.
20 Eventually, evidence from implementation of the
21 suite of performance measures can inform such a
22 global malnutrition score.

1 Due to the nature of these measures
2 and their alignment with the nutrition care
3 process and our clinical workflow in the
4 hospital, I just wanted to make sure that we
5 inform the committee, and I know that it has
6 already just been mentioned that our intention
7 for the four measures follows the nutrition care
8 process. So, therefore, the order of the
9 measures would be a screening assessment, and
10 then the intervention plan of care, and then the
11 malnutrition diagnosis.

12 So, with that, I would just like to
13 thank you again for the opportunity to introduce
14 these measures to the standing committee, and we
15 look forward to your questions that you have on
16 these measures.

17 CO-CHAIR QASEEM: Thank you so much.
18 So, let's start off with our first measure. It
19 is Measure 3090: Appropriate Documentation of
20 Malnutrition Diagnosis. And let's go with our
21 leads, Amy and Jacki. Go ahead.

22 MEMBER SPANGLER: Can I ask a question

1 real quick to the developers?

2 CO-CHAIR QASEEM: Sure.

3 MEMBER SPANGLER: Did you guys
4 consider putting all four of these into a
5 composite measure? And if not, why not?

6 MR. VALLADARES: Great. Hi, everyone,
7 my name is Angel Valladares. Yes, that is
8 something that we actually have been discussing
9 in our engagement with the multi-stakeholder
10 group that Sharon mentioned and also with CMS.
11 So, it was actually something that CMS brought to
12 our attention as something that they would want
13 to sort of pursue in the future. However, of
14 course, in our research and in the development of
15 these measures, we needed to first implement and
16 develop individually performing measures that we
17 can ensure that all individual measures have a
18 performance score. And then once they are
19 implemented over time, and we can sort of do more
20 -- generate more evidence around those four
21 measures and how they relate to each other, the
22 goal is to develop that global malnutrition

1 score, where we could then have the users of the
2 measures monitor on sort of the performance of
3 the entire nutrition care process.

4 So, I think that is the eventual goal.

5 MS. MCCAULEY: And our concentration
6 is that hospital inpatient stay for that elderly
7 population.

8 CO-CHAIR QASEEM: So, Matt, on this,
9 I would rather not get into the discussion of
10 composite measure. Let's just go over it measure
11 by measure because that is not what we have in
12 front of us today.

13 So, Measure 3090, Amy or Jacki, you
14 guys would like to open?

15 MEMBER AUERBACH: I should note: This
16 is John. Again, this is not about that but just
17 a clarification.

18 CO-CHAIR QASEEM: John, I would really
19 like to interrupt -- I am so sorry -- because we
20 are running behind on the agenda. So, we would
21 like to move on with the individual measure
22 review.

1 Amy, Jacki?

2 MEMBER MINNICH: Sure, and Jacki, feel
3 free to entertain any additional conversation.

4 So, first of all, I want to make a
5 clear distinction because a lot of the detail
6 that we are going to be talking about in this
7 measure there is a distinction between the
8 documentation of a diagnosis of malnutrition
9 versus nutritional screening assessment
10 intervention. And so that applied to a couple of
11 the different pieces of this measure in specific.

12 So relative to the evidence, that
13 really came through. There was limited detail
14 relative to that documentation process. We
15 certainly recognize it is an important measure
16 but, based on the evidence that we have
17 presented, there was a concern that there was
18 insufficient information to make that
19 determination.

20 Jacki.

21 MEMBER MOLINE: I second that
22 completely. I was waiting to see -- you

1 mentioned that there was a malnutrition score
2 that you are hoping to develop but there wasn't
3 -- it seemed like the measure was begging to have
4 that as what was going to be documented. So, it
5 was unclear to me how people could be judged on a
6 nebulous measure. And to me, it was nebulous in
7 that it wasn't clearly specified what you meant
8 by malnutrition in terms of how it would be
9 captured. And that led to some questions that we
10 had in the review.

11 MEMBER MINNICH: I think the other
12 point is around disparities. There was really no
13 reference to any type of disparities, other than
14 what you have mentioned with the geriatric
15 population.

16 CO-CHAIR QASEEM: Any other general
17 comments, before we start going from -- Cathy?

18 MEMBER HILL: Yes, just as a general
19 comment, as someone who is board certified in
20 geriatrics, a nurse practitioner who works with
21 these patients every day in the hospital and sits
22 on readmission committees that look at what

1 brings our elders back into the hospital, this is
2 a really important topic for us in Texas and it
3 was when I was in Florida. So, I would encourage
4 you to give real specific feedback to the
5 measures developer because I can tell you that
6 every day I put on diagnoses of, you know,
7 underweight and especially in our stroke patients
8 and our community-acquired pneumonia patients,
9 which we have already talked about. These people
10 are coming back because they are malnourished and
11 our treatments, our medical treatments aren't
12 working.

13 So, I really appreciate the fact that
14 you have brought this to this group because it is
15 an important wellness and health factor,
16 nutrition.

17 MS. MCCAULEY: No, we have --

18 MEMBER MOLINE: I don't think that
19 there is any doubt about the importance of this.
20 I think as we were trying to go through and look
21 at the measure, we were looking at what was
22 presented to us. And what we were looking for

1 was some specificity; especially this one was
2 looking as an eMeasure and was trying to figuring
3 out what they were measuring.

4 So, that was really the issue, not the
5 importance and its effect on morbidity and
6 mortality.

7 MEMBER HILL: Yes, I appreciate that.
8 And I was just trying to bring some personal
9 experience to it so that you could hear that it
10 is out there.

11 MEMBER MOLINE: It is clearly an
12 important issue but the question in front of us
13 is really more -- boy, I sound like I'm on that
14 side of the table -- but the question in front of
15 us is --

16 CO-CHAIR QASEEM: Are you an attorney?

17 MEMBER MOLINE: Yes, I spend too much
18 time with them. The question really is what are
19 we looking for to use as a measure.

20 CO-CHAIR QASEEM: Do you have a quick
21 response?

22 MR. LYNCH: Sure. My name is Joe

1 Lynch. I am a Director with Avalere Health.

2 The primary thing that we are looking
3 to measure is the actual medical diagnosis of
4 malnutrition and the rate at which it is being
5 done. If we look purely at how the medical
6 diagnosis is documented, we have looked at it and
7 saw the rate are down in the three to four
8 percent of the actual ICD-9, ICD-10 documentation
9 of diagnosis. But if you look at the literature
10 and the studies around the rates of malnutrition,
11 the estimation in the same time period is
12 anywhere from 33 to 54 percent. So, there is a
13 humongous gap in how effectively diagnosis is
14 being documented in the patient record versus
15 what is estimated to be the prevalence of the
16 condition in the population at large, especially
17 the 65 and older group.

18 So, the goal to this particular
19 measure is to help to inform this concept of a
20 global malnutrition score based on how
21 effectively the clinical documentation of this
22 diagnosis of malnutrition is taking place.

1 MS. MCCAULEY: And just to move
2 backwards to explain a little bit more about the
3 diagnosis and I understand -- thank you for your
4 comments -- it is the end result of going through
5 that process and that clinical workflow.

6 So, I understand what you are saying.
7 You want that stand-alone measure to have I guess
8 that cause and effect. But what we do is making
9 sure that the screening, the assessment, and we
10 work with a multi-disciplinary team to have that
11 happen through that nutrition care plan to make
12 sure that we work with a physician to get to that
13 diagnosis. And that is how we approach this
14 measure suite.

15 CO-CHAIR QASEEM: So, Marcel and then
16 Tom.

17 MEMBER SALIVE: Though, I didn't hear
18 us discuss this for pneumonia and I think -- I
19 appreciate that malnutrition is underdiagnosed in
20 the hospital and that that is the focus of this
21 measure, I do think it is an important issue and
22 it is worthy of our consideration. And so I am

1 not clear on why that is the focus on the
2 evidence section here. You know we, generally, I
3 think accept diagnosis codes that are in the
4 records and that is what you are saying here.

5 So, you know maybe it is way vastly
6 under-reported now but I do think that, as we
7 discuss these other measures, we will get to
8 that. But if you don't do screening and if
9 people aren't looked at in the hospital, it won't
10 be picked up. And I think it is worthy of doing
11 and it is a point of starting the process, when
12 it could happen.

13 People are, essentially in the
14 hospital. They have to eat there. I mean unless
15 they are unable to eat, their nutritional needs
16 have to be met. So, it seems reasonable to me as
17 a focus for a measure. And I think there was
18 some evidence that was presented that is
19 sufficient for this to be a measure. Although,
20 personally, I think, some of the other measures
21 might be better. But I don't understand -- maybe
22 the reviewers can explain this better but I don't

1 understand why that is your issue. We didn't --
2 I guess we discussed with pneumonia that some are
3 viral, some are bacterial, but we didn't say
4 people can't diagnose it.

5 CO-CHAIR QASEEM: Amy, Jacki, you want
6 to comment? Since we are getting into the
7 evidence piece anyways, we can talk about
8 evidence even from the staff aspect of it.

9 DR. NISHIMI: Yes, I mean there is
10 evidence for each measure is what I heard the two
11 reviewers say and that the evidence that was
12 cited is more relevant to the other measures, not
13 to this measure. I don't want to put words in
14 your mouth but I think that is what they are
15 saying.

16 So, we'll get to those but the measure
17 right now is just the documentation.

18 CO-CHAIR QASEEM: Matt?

19 MEMBER STIEFEL: I apologize. I can't
20 not talk about the combination because we are
21 going to fall into the same trap as we did
22 before, that the evidence is insufficient for

1 each of the independent measures but the evidence
2 may more appropriately apply to the bundle.

3 So, I have a feeling we are going to
4 go through this process of insufficient evidence
5 in each of the components.

6 CO-CHAIR QASEEM: John, why don't you
7 chime in? This will be a good opportunity since
8 Matt brought it up.

9 MS. MCCAULEY: I don't think it will--

10 CO-CHAIR QASEEM: Matt brought it up
11 again. John, do you want to say a few words
12 about the whole composite measure issue? You
13 were planning to chime in earlier.

14 MEMBER AUERBACH: Thank you very much.
15 The question I had, which I think applies to all
16 but, certainly, we can limit it to this measure
17 for now, is whether or not you are making a
18 recommendation that the screening occur for
19 elderly patients or for all patients above 18
20 years and older.

21 Partly, this is a question related to
22 the evidence, since part of what the evidence --

1 part of the submission of the evidence focuses on
2 the elderly and your comments have focused on the
3 elderly.

4 So, could you clarify whether this is
5 a more of -- you know what the focus of the
6 population and perhaps whether or not that has an
7 impact on the availability of evidence?

8 MS. MCCAULEY: We decided that the
9 screening tool that we were using will be for all
10 patients, 18 and above. So, that is our first
11 measure that we had worked on.

12 And moving forward, we isolated it to
13 the inpatient elderly hospitalized.

14 DR. NISHIMI: Just to address Matt's
15 concern about insufficient, I don't think you
16 will reach that conclusion, just to preview the
17 other measures and the reviews that folks have
18 laid out. I don't think the committee will reach
19 an insufficient conclusion. This was the measure
20 about which I think people are likely to --

21 MEMBER STIEFEL: But then the problem
22 is that the other measures, without this one, are

1 insufficient, to achieve the outcome goal.

2 MEMBER MOLINE: No, one is a screening
3 for it and then the other is to put in the record
4 as a diagnosis.

5 So, I think they are actually, one is
6 looking did you do the screening and I think that
7 is what we will be hearing about later.

8 The other is you did the screening.
9 Did someone pay attention to the screening and
10 actually add that as one of the diagnoses that
11 would then be acted on to improve the quality?

12 So, they are actually -- the screening
13 needs to come first. Is it happening? Because
14 you need the screening in order to get the
15 diagnosis but I think this measure is saying once
16 you get the diagnosis, is it actually making it
17 into -- is it actually getting truly documented
18 and is there evidence that there is ease of doing
19 that and how it is being done?

20 DR. STEIBER: Hi, this is Alison
21 Steiber. I am the Chief Science Officer for the
22 Academy and I would love to just briefly address

1 that point.

2 So, I apologize if I am a little
3 unclear of the process here.

4 So, we have pretty good evidence from
5 a long history of JCAHO requiring screening in
6 the hospital within the first week of admission
7 --

8 DR. NISHIMI: If you could hold your
9 -- I'm sorry to interrupt you but the committee
10 is discussing this measure now. If you could
11 hold you comment on screening, when we get to
12 that screening measure.

13 DR. STEIBER: Okay.

14 DR. NISHIMI: We are just talking
15 about the document -- evidence around
16 documentation per se right now.

17 DR. STEIBER: Right. So, I guess I
18 was just going to comment on the disconnect
19 between the screening happening and the diagnosis
20 occurring. Is that appropriate to speak on at
21 this moment?

22 DR. STEIBER: It is appropriate to

1 comment on the documentation of the diagnosis
2 because that is what this is; not the diagnosis.

3 DR. STEIBER: Right. Okay, so my
4 point was just simply that we have evidence
5 through a number of surveys that were conducted
6 that there is a disconnect between people who are
7 being screened at risk for malnutrition and the
8 documentation of the diagnosis of malnutrition
9 and yet while we have that significant disconnect
10 in that documentation of diagnosis of
11 malnutrition, there is evidence to indicate that
12 we can successfully diagnose malnutrition and
13 when that is done, we have a difference in
14 survival rates and in costs in the hospitalized
15 patient population.

16 CO-CHAIR QASEEM: Cathy.

17 MEMBER HILL: Yes, and I agree that
18 what I -- just from a practical standpoint, what
19 we see happening is that our -- I am most
20 involved with elders because that is 50 percent
21 of my inpatient population in rural Texas. We do
22 see them getting haphazardly screened and our

1 estimates in our readmission efforts have been
2 anywhere from 13 to 78 percent of our population
3 have needs that are not being met.

4 The interventions are been getting
5 done separate and apart from the diagnosis, which
6 has been problematic in terms of driving a
7 consistent process that improves the health of
8 our patients and reduces our readmission rate.
9 So, the diagnosis is a part of, I think as Matt
10 had suggested, is a part of how you get it done
11 is establishing that label.

12 CO-CHAIR QASEEM: So, I think we can
13 vote on the evidence piece of this, at this
14 point.

15 MS. CRAWFORD: Voting on Measure 3090,
16 evidence. One, high; two, moderate; three, low;
17 four, insufficient.

18 MEMBER BAER: Hi, this is Mike Baer.
19 I just wanted to let you know that I did join. I
20 was unable to join earlier but I am here now and
21 I did vote via the chat.

22 DR. NISHIMI: Thanks, Mike.

1 MS. CRAWFORD: Zero high; five
2 moderate; four low; seven insufficient. 31
3 percent moderate, 25 percent low, 44 percent
4 insufficient.

5 DR. NISHIMI: So, the measure does not
6 pass the must-pass criterion of evidence. I am
7 going to move on to the next measure.

8 CO-CHAIR QASEEM: Okay, so the next
9 measure is Measure 308 -- actually, can I just
10 change the sequence around this time around?
11 Because I think it would make more sense if we
12 discuss the screening first --

13 DR. NISHIMI: Sure.

14 CO-CHAIR QASEEM: -- which is measure
15 3087. And I think it's the same reviewers,
16 correct? I think it is Jacki and Amy. Am I
17 right or am I wrong? Hold on, I have a cheat
18 sheet I have to look at.

19 DR. NISHIMI: 3087.

20 CO-CHAIR QASEEM: Sorry to move things
21 around. Sorry, guys but I think it will make
22 more logical sequence.

1 Okay, so it is Cathy and Barry is not
2 there and Ron. So, Cathy and Ron. Who would
3 like to --

4 MEMBER BIALEK: I'll chime in
5 initially, okay?

6 So, this measure is to have screening
7 done within 24 hours of an individual being
8 admitted to the hospital. And the progression is
9 screening and then it is screening would identify
10 high risk. High risk then would result in a more
11 complete assessment, which then could go into
12 diagnosis, treatment, et cetera.

13 And as far as the evidence is
14 concerned, the evidence presented demonstrates
15 that there are adverse health outcomes associated
16 with malnutrition and that the intent of the
17 measure, again, is to start the process of
18 screening to assure that, ultimately, it can lead
19 to the diagnosis and treatment.

20 So, that is the evidence piece.

21 MEMBER HILL: I agree. I don't have
22 anything to add. I think the evidence is there

1 and my experience over the last 30 years would
2 support that.

3 DR. NISHIMI: You can see from the
4 staff PA -- can you call that up -- that there
5 was a systematic review of the evidence, the
6 quality, quantity and consistency. It has
7 provided the evidence was graded. Depending on
8 the particular sub-recommendation, if you will
9 the grades and level of evidence were different
10 but there was grading provided. So, the
11 committee can vote. It is eligible for high and
12 the committee can vote on evidence.

13 CO-CHAIR QASEEM: So, before we vote,
14 Ron, Cathy, a question for you. And please, I
15 reviewed this measure a while ago and I have some
16 notes over here and I was looking at it.

17 My question, and I am not disagreeing
18 with you, Cathy, what you are saying is that this
19 is talking about screening all patients over 18
20 years, rather than just ICU patients, older,
21 elderly, right, the population that you were
22 talking about?

1 And one of the notes I have from the
2 measure reviewers, if it is in the measure
3 somewhere, I have it in quotes, which says in the
4 additional comments included below, the measure
5 developer would like to acknowledge that it is
6 difficult to measure patient outcomes in the
7 nutrition space, particularly to associate
8 outcomes with only one of the steps of nutrition
9 care in the overall nutrition care process, et.
10 al.

11 So, my concern is that maybe I am
12 forgetting it but, Ron, it is all patients. Did
13 they present evidence for all patients in there
14 or did I miss it? I understand the ICU patients.
15 I understand the elderly and all. You are
16 talking about everyone over the age of 18. Are
17 you looking at almost, quite a big chunk of U.S.
18 population who is going to start getting this
19 screening done?

20 MEMBER HILL: Well, my additional
21 focus is in rural health, where socioeconomic
22 issues abound and I frequently have patients who

1 say they don't have access to good water --

2 CO-CHAIR QASEEM: Absolutely.

3 MEMBER HILL: -- and they don't have
4 access to food.

5 CO-CHAIR QASEEM: Yes. So, I mean it
6 is a specific population. I'm not disagreeing on
7 specific population at all. I am talking about
8 they are talking about screening everyone.

9 Is there evidence for screening
10 everyone, every adult person in the U.S.?

11 DR. STEIBER: This is Alison Steiber
12 again. Just to indicate that the data that is
13 out there on screening and prevalence of risk for
14 malnutrition is not subjected to just 65 and
15 over. Most of the data that we have globally
16 includes adults 18 and over and so that 33 to 54
17 percent that Joe quoted before is from a
18 population that is general adult, not just for
19 elderly.

20 MR. VALLADARES: And this is Angel.
21 I just wanted to add that the guideline that was
22 cited for support for this measure does recommend

1 screening for nutrition risk for all hospitalized
2 patients. So, that is something we wanted to
3 add. It doesn't distinguish between age ranges.

4 CO-CHAIR QASEEM: And what was the
5 rating for the evidence? That is exactly the
6 concern that I am raising.

7 MR. VALLADARES: Right. Great. And
8 so I think that goes back to the comment that we
9 had made, that you brought up in the additional
10 comments for the measure submission. So, one of
11 the challenges that we have in the nutrition
12 space with research is sort of the inherent way
13 that a lot of the research is designed. There
14 isn't a lot of randomized control trials, as you
15 can imagine on malnutrition and screening. So, a
16 lot of the evidence, unfortunately, stays in the
17 traditional research space more on the level, I
18 think it is Level 3, and 4, and 5 as we define
19 it.

20 So, a lot of it is on observational
21 studies, cohort studies, retrospective reviews,
22 as opposed to pro-RCT type of research. And so I

1 think that is where the issue is. But in terms
2 of the volume of research, it goes back decades,
3 confirming the prevalence hasn't changed. In
4 fact, it is getting worse as our population ages.
5 So, it is a continued issue but I do understand
6 it.

7 CO-CHAIR QASEEM: Absolutely. And I
8 will come to Arjun and Cathy just to respond to
9 that. And disclosure: I am a member of, being a
10 member of the Grade Working Group. Just because
11 you don't have evidence from a randomized
12 controlled trial does not make it a low quality
13 evidence. I think that is something that we need
14 to keep it in mind.

15 If you are unable to derive practical
16 recommendations based on randomized controlled
17 trials, you can still upgrade observational
18 studies as well. So, I am going to a little bit
19 disagree with that.

20 I think the reason that was rated as
21 Grade E is because it is Grade E for various
22 reasons that are in that guideline. That is why

1 I was bringing up that issue.

2 Arjun and then Cathy.

3 MEMBER VENKATESH: So, I guess from an
4 evidence perspective, I am hearing that this is
5 probably again down that path of insufficient
6 evidence and then you have to decide if you want
7 to make an exception or not based on
8 international or national consensus statement. I
9 think when you make a recommendation for a
10 quality measure evidence based on a specialty
11 society consensus statement, we need to look
12 through and make sure that that consensus
13 statement grading was appropriate and things like
14 that. And I haven't looked at that detailed a
15 measure.

16 My issue with this, also sort of
17 related to that, issue about the evidence is that
18 the measure itself is set up so that -- sorry --
19 I'm trying to find it -- if we were to do this,
20 it is not innocuous to do this on very low levels
21 of evidence.

22 There is something probably around 25

1 or 30 million inpatient hospital discharges --
2 inpatient. This measure is not specific to
3 inpatient observations. So, if you included
4 both, people who stayed in the hospital 24 hours,
5 you are looking at something on the order of 35
6 million, let's say, times a year, where you would
7 have to screen people and this would include
8 things such as somebody comes in for elective
9 gallbladder surgery would now need to get a
10 malnutrition screening. Every single
11 hospitalization.

12 This is a very broad screening
13 measure. And to me, I think there needs to be
14 some level of evidence that suggests that our
15 pretest probability for malnutrition, our
16 suspicion of malnutrition, you know screening is
17 smart. We wouldn't accept the same level of
18 standard for screening. If somebody just came in
19 with a colonoscopy measure and said we should do
20 a colonoscopy on everybody above the age of 18,
21 we would say no.

22 And so I think that -- I do think it

1 really matters, at least on the age or some other
2 risk elements of a patient. I understand there
3 are many people under 65 who are certainly at
4 high risk and there are probably ways to define
5 that risk cohort, based on observational
6 research. You don't need randomized trials. But
7 I think a broad measure of everybody above the
8 age of 18, 30 or 40 million times a year in the
9 U.S. just seems a little excessive.

10 MEMBER HILL: Well, tangentially, I
11 think, related is the fact that in population
12 health and in outpatient settings, we often feel
13 like it is appropriate to talk to people about
14 their nutrition. And we all embrace the role
15 that nutrition has in staying healthy and well.
16 Many patients have a disconnect, as do providers,
17 that all of a sudden you come into an acute care
18 setting. We don't really care to make that
19 connection between what is going on with your
20 hospital stay and your ability to get well
21 successfully and your nutrition and how that
22 plays a role. And we are at the beginning, I

1 think, of trying to do that, to harmonize with
2 the message that we give to populations about
3 lifestyle, and the 30 percent role it plays in
4 how well you are, and connecting that in the
5 acute care setting, so that that remains a
6 relevant part of the role and gets reinforced by
7 people who are respected and trusted, like
8 physicians and nurses and dieticians and
9 nutritionists.

10 DR. STEIBER: Sorry, this Alison
11 Steiber one more time. I couldn't --

12 DR. NISHIMI: Alison, can you let the
13 committee --

14 DR. STEIBER: Oh, sorry. Sorry.

15 MEMBER SALIVE: In reviewing the
16 measure, what I didn't see is the extent of the
17 initial screening. What I took away from the
18 description is that it wasn't all that extensive
19 in that the more extensive is the malnutrition
20 assessment that will be prompted by this initial
21 screening that didn't seem to be all that time
22 consuming. But that wasn't explicitly said in

1 there.

2 Secondly, the other thing I would say
3 is that the evidence presented does show that use
4 of a validated screening tool does identify both
5 within the elderly and the general population
6 more high risk that leads to the full assessment,
7 that leads to diagnosis of malnutrition. So,
8 that was presented, I believe, in the evidence.

9 But the measure itself, screening,
10 isn't specific to use of the validated screening
11 tools. While that is recommended, that is not
12 specific in here. So, it was tough to really
13 gauge all of the evidential pieces in that using
14 screening in general, it is not validated. I
15 would say that there was not evidence for using
16 just a general tool that is not validated but
17 there was evidence for using the validated tool
18 but the measure doesn't specify it has to be a
19 validated tool.

20 MEMBER SALIVE: So, maybe this is out
21 of order. I agree with Ron a little bit but I
22 think this is -- the sure tools that I am

1 familiar with and that are cited in the guideline
2 include BMI, which we will get to in one of the
3 other measures, which is why I say it is out of
4 order, and then it just has like four questions.

5 So, this is not like super complicated
6 and it is basically have you been eating less in
7 the last three months. I mean that is very
8 simple. People can answer that. And have you
9 lost weight in the last three months?

10 And then the other two are related to
11 more like physical and mental illness. So, I
12 think that is known on the hospital admission.
13 This is not super complicated. I think that
14 people do need to be fed. This is not
15 burdensome.

16 So, yes, okay, if you don't say it is
17 a validated instrument and maybe there is some
18 wiggle room but that instrument is very simple.
19 And we will get to the one on BMI, which I think
20 has strong evidence and strong recommendations.
21 So, that is a component of this screening and it
22 is probably the most important component, I would

1 guess.

2 CO-CHAIR QASEEM: Okay, so Alison and
3 then the team.

4 MR. LYNCH: This is Joe. Actually,
5 first to address the burden here. Up until just
6 the beginning of this year, the Joint Commission
7 required that malnutrition screening occur within
8 24 hours of admission. The issue with that is
9 there was no measure associated with collecting
10 information about that screening. So, it was a
11 check the box process with Joint Commission
12 accreditation. So, this is not new. The idea of
13 doing this isn't new. It is part of the process
14 already.

15 The validated screening tools, though
16 important, and you are absolutely correct, the
17 evidence does support using the validated
18 screening tool more specifically, the fundamental
19 issue we ran into is the ability to actually
20 capture that bit of information in the EHR. So,
21 the ability for us to verify the existence of a
22 validated screening tool and the measure was a

1 challenge, at least at this point. Measurement
2 can change that behavior, ultimately, but as the
3 data exists today, that is difficult to do.

4 And to answer your question about the
5 complexity of the tool, it is usually about three
6 questions. It is a very simple screening process
7 to get it done.

8 But in terms of to address the overall
9 issues, it is a very simple process to get done
10 and is shown to really drive how effectively
11 further evaluation of a person's care and the
12 existence of malnutrition is a sensitive enough
13 tool to identify those at risk for or usually at
14 high risk for malnutrition. The middling ranges
15 in the potential for risk will start to bubble up
16 to the surface but that is not the intent of the
17 tool. It is really to identify where things can
18 be addressed, where the evidence really supports
19 that intervening, at this point, does result in
20 much improved outcomes.

21 Did you have anything else more you
22 want to add?

1 CO-CHAIR QASEEM: Alison, do you want
2 to add anything?

3 DR. STEIBER: You know I guess I was
4 just going to point out that one of the
5 challenges, even from the JCAHO time when they
6 were mandating this is that every hospital had
7 their own concept of what was needed for a
8 screening tool. And I think the original intent
9 was really to use a validated tool but the
10 question of feasibility came into play whether
11 that was feasible for one tool to meet the needs
12 of every hospital, whether it is a community-
13 based hospital or a tertiary medical center. And
14 so I think that it was felt that it was more
15 feasible to have a little bit more open ability
16 for the hospitals to have tools that they felt
17 would be effective for them to identify risk of
18 malnutrition.

19 And clearly, as Joe nicely put it, the
20 goal is to improve outcomes. And so we have to
21 figure out how to support the facilities to do
22 that in ways that are feasible for them.

1 CO-CHAIR QASEEM: So, I think we are
2 probably ready to vote on the evidence. Marcel,
3 do you have a comment? Oh, okay. Let's vote,
4 folks.

5 MS. CRAWFORD: Voting is open on
6 Measure 3087, evidence. One high; two moderate;
7 three low; four insufficient.

8 One more. And we have eight moderate;
9 two low; six insufficient. So, 50 percent
10 moderate, 13 percent low, and 38 percent
11 insufficient.

12 DR. NISHIMI: So, that is consensus
13 not reached and we will keep discussing this.

14 CO-CHAIR QASEEM: Okay, so let's keep
15 discussing it.

16 DR. NISHIMI: We will discuss the
17 other criteria, I should say, not that we are
18 going to continue discussing this.

19 CO-CHAIR QASEEM: You want to get to
20 the gap part now, right?

21 DR. NISHIMI: Right.

22 CO-CHAIR QASEEM: Okay.

1 MEMBER BIALEK: So, a performance gap
2 was demonstrated but what I wanted to point out
3 is that the data come from only two hospitals and
4 there was no information on generalizability.

5 DR. NISHIMI: So, that is something
6 for the committee to consider in its
7 deliberations.

8 CO-CHAIR QASEEM: Cathy, do you have
9 any comments?

10 Any general comments no gap? Okay, so
11 let's vote on gap.

12 MS. CRAWFORD: Voting on Measure 3087
13 on performance gap. One, high; two, moderate;
14 three, low; four, insufficient.

15 We have four high, nine moderate, two
16 low, one insufficient. So, 25 percent high, 56
17 percent moderate, 13 percent low, 6 percent
18 insufficient.

19 DR. NISHIMI: So, the measure passes
20 on gap and we will go to the scientific
21 acceptability. That is the reliability of the
22 specifications, the reliability testing and the

1 validity testing and assessments of threats to
2 validity.

3 So, Ron and Catherine.

4 MEMBER BIALEK: In terms of
5 reliability and validity and testing, the measure
6 itself, again, was for screening. And the
7 determination of if somebody has been screened
8 really seems to be up to the provider, him or
9 herself, the coder, him or herself. There really
10 was no specificity on what is screening.

11 And the evidence, again, about using
12 a valid tool was clear but you could code it as
13 somebody being screened without using that tool
14 or any standard process. And so I found some
15 difficulty in the reliability of the
16 specification of the data, as well as the
17 comparability as a performance measure that
18 screening is not the same as screening, depending
19 upon the provider, the institution, et cetera.

20 CO-CHAIR QASEEM: Cathy, any --

21 MEMBER HILL: Well, there is something
22 to be said for the fact that this has been

1 suggested for the inpatient setting. So, you are
2 going to be screened by licensed, credentialed
3 people and while that may not be, at this point,
4 may not be standardized across the nation with
5 the same four questions or three data points, you
6 are getting a level of expertise there that is
7 appropriate to the acute setting.

8 CO-CHAIR QASEEM: Any other comments?

9 So, I have a combination of comments. This is
10 reliability, validity and the EHR altogether.

11 So, there are no exclusions for this
12 measure, my understanding is, and which surprised
13 me a little bit because when you conducted the
14 EMR feasibility yourself, you excluded patients.
15 You excluded patients discharged before 24 hours,
16 discharged before hospice, and then two or three
17 other categories in there.

18 So, what confuses me is that you don't
19 have an exclusion but when you tested the
20 measure, you had exclusions yourself.

21 MR. VALLADARES: That is a great
22 point. So, I think before we conducted the

1 actual validity and reliability testing, we did
2 test for feasibility on those particular sub-
3 populations. Once we did testing, and you will
4 see that in the reliability and validity testing
5 that we ran tests on both patient populations,
6 excluding those patients and patient populations
7 not excluding. So, we did run a pretty specific
8 measure exclusions analysis on both of the
9 testing sites and the cohorts. We did not find
10 that the exclusion of -- first of all, the
11 exclusion and the number of patients that were
12 excluded were very small. It was a three to five
13 percent, if I recall.

14 And then, in addition, once we looked
15 at whether it would impact the data element
16 results or the measure performance results, it
17 had no significant impact at either level. So, I
18 think that that is the reason we wanted to
19 present the way we had the feasibility first
20 tested but then we showed in the measure
21 exclusions analysis that our initial indications
22 for excluding those patients, which was supported

1 by, you know they were things that were brought
2 to consideration to us by the technical expert
3 panel. And then once we presented that
4 information back to the technical expert panel
5 and we had the reliability and the validity
6 testing scores, they agreed that because it had
7 no actual impact that we could assess through
8 statistical analysis. we shouldn't include them
9 until such time in the future where there are
10 larger amounts of hospitals that might change the
11 evidence.

12 MEMBER VENKATESH: So, I guess this is
13 maybe more guidance on this issues, in some ways,
14 which is that the vast majority of exclusions for
15 most quality measures will not be captured in any
16 meaningful or high rate. And for example here,
17 you only looked at 200 records. I'm not
18 surprised that these three things happened at
19 very low, if did not happen at all.

20 I would say that my interpretation of
21 this same stuff that you have presented here is
22 that you had a technical expert value that said

1 the face validity of your measure requires that
2 you exclude these three populations because it
3 would be unreasonable to expect that they get
4 screened within 24 hours. You evaluated whether
5 or not those can be feasibility captured. I
6 think they all can because they are actually part
7 of other eMeasures that exist. Look at the ED
8 throughput measures include all of these to some
9 degree in electronic specifications. So, they
10 can feasibly be captured.

11 Looking at scores with and without
12 exclusion had a high degree of correlation. So,
13 there is not something systematic about
14 exclusions that throw off your scores but you can
15 still keep them in as denominator exclusions
16 because they improve the likely meaningfulness of
17 the measure.

18 You could imagine that if you
19 eventually roll this out on every
20 hospitalization, thousands and thousands, you are
21 certainly going to have all three of these things
22 happening with some different degree between

1 different facilities. Hospitals have different
2 rates of referral to hospice. They are going to
3 have a different amount of short stays. They are
4 going to have different amounts of patients that
5 leave AMA.

6 And so for all the reasons that your
7 experts said make them exclusions, I would make
8 them exclusions. I guess I would come to a
9 different conclusion with the exact same data
10 findings you have here.

11 CO-CHAIR QASEEM: Okay, any other
12 comments? And then we can vote.

13 MEMBER HILL: I would like to agree
14 with that and I do know that when you are trying
15 to -- this is a trial measure -- no?

16 DR. NISHIMI: This is not a trial use
17 measure. This is a measure for endorsement.

18 MEMBER HILL: All right. Then, the
19 adoption of measures is definitely influenced by
20 the exclusions seeming reasonable to the level
21 that you are going to implement it.

22 CO-CHAIR QASEEM: Okay, so let's vote,

1 please.

2 MS. CRAWFORD: Voting on Measure 3087,
3 reliability. One, high; two, moderate; three,
4 low; four, insufficient.

5 DR. NISHIMI: Re-click.

6 MS. CRAWFORD: One more. Zero high,
7 11 moderate, 2 low, 3 insufficient. So, 69
8 percent moderate, 13 percent low, 19 percent
9 insufficient.

10 DR. NISHIMI: So, we can continue and
11 discuss validity, which is where the exclusions
12 discussion really belongs.

13 CO-CHAIR QASEEM: So, any further --
14 go ahead, Ron. Shall we vote?

15 DR. NISHIMI: Is everyone comfortable
16 with no additional discussion? We can vote,
17 otherwise.

18 CO-CHAIR QASEEM: I think we can vote.
19 Let's vote because we have combined the
20 discussion last time.

21 MS. CRAWFORD: Okay, voting is open
22 for Measure 3087, validity. One, high; two,

1 moderate; three, low; four, insufficient.

2 One more vote.

3 We have one high, nine moderate, five
4 low, one insufficient. So, 6 percent high, 56
5 percent moderate, 31 percent low, 6 percent
6 insufficient.

7 DR. NISHIMI: That is 62 percent high
8 or moderate. So, it passes on validity.

9 CO-CHAIR QASEEM: Okay, so
10 feasibility, Cathy and Ron?

11 MEMBER BIALEK: Okay, feasibility.
12 So, this can be publicly reported. So, did you
13 just say feasibility or usability?

14 CO-CHAIR QASEEM: Feasibility.

15 MEMBER BIALEK: Feasibility. I'm
16 sorry, feasibility. I actually thought there was
17 insufficient information to determine this across
18 hospitals just because there were two hospitals
19 in the sample and, again, no information on
20 generalizability. So, I really couldn't weigh in
21 on that.

22 CO-CHAIR QASEEM: Go ahead.

1 MR. VALLADARES: So, in response to
2 that comment, one thing we did want to clarify
3 because I feel that it hasn't been included in
4 the discussion on feasibility is we actually
5 tested on three hospitals, feasibility and we
6 also tested on three national EHR vendor
7 platforms.

8 So, we worked with Epic Systems,
9 Cerner, as well as Allscripts, who are three of
10 the largest EHR vendors for hospitals and they
11 all provided sufficiently, well we believe, at
12 least, above average feasibility, saying that
13 they were able to capture this data
14 electronically in their systems and they felt
15 that the coding and value sets that we included
16 to categorize the components of this measure were
17 absolutely capturable to their customers.

18 And just as sort of a quantitative
19 assessment, if you aggregate the hospital
20 platforms that those three vendors are
21 responsible for represents a little over 30
22 percent of the U.S. hospital market who have 2014

1 certified EHR technology.

2 CO-CHAIR QASEEM: Go ahead.

3 MEMBER BAER: So, can this be
4 generalized to all certified EHRs?

5 MR. VALLADARES: That's a great
6 question. So, yes, these data elements represent
7 value sets that follow the healthcare quality
8 measure format and they are all approved in the
9 VSAC so they are, again, up to the national
10 standards. Our three EHR vendors who we work
11 with confirmed that the measures -- or sorry --
12 that the data elements and the value sets
13 included in those data elements represent a
14 nationally standardized data that is already
15 implemented in their platform, in their suite of
16 platforms that they provide to their hospitals.

17 CO-CHAIR QASEEM: Katie.

18 MEMBER SELLERS: Yes, I just had a
19 clarifying question for NQF. I believe the
20 threshold requirement is to test it in two sites,
21 right? So, they are well above that threshold.

22 DR. NISHIMI: Two systems, yes.

1 MEMBER SELLERS: Systems.

2 DR. NISHIMI: Two systems.

3 MEMBER SELLERS: Yes.

4 CO-CHAIR QASEEM: Except, just so to
5 follow-up, Katie, on what you just said, to my
6 knowledge and, again, I am not the expert in this
7 field, you are talking about screening everyone
8 over the age of 18 and most hospitals do not have
9 enough dieticians to be able to consult among all
10 patients who might be needing this. And I don't
11 know if your hospitals, the three hospitals that
12 you included. Where did they fall into?

13 Because the lack of dieticians -- you
14 screen if you are going to be able to provide
15 certain services and adequate treatment. If you
16 are not going to have the follow-up in place, you
17 do not screen. That is the basic rule for any
18 screening recommendation. So, these three
19 hospitals that you guys had, the dietician to
20 patient ratio or if you can speak about --

21 DR. STEIBER: Is it appropriate for me
22 to comment on that? This is Alison.

1 CO-CHAIR QASEEM: All right. Go
2 ahead, Alison.

3 DR. STEIBER: Great, thank you. So
4 just to clarify, in most hospitals, as soon as --
5 it is not the registered dietician/nutritionist
6 who does the screening. Screening usually is
7 done by either dietary technician registered or
8 often by the nursing staff. And so it is not
9 until the assessment step occurs that the
10 dietician would step in.

11 So, I certainly agree with your point
12 on staffing issues but the screening step really
13 typically is not done by your registered
14 dietician. So, the staffing typically has not
15 been an issue, at least when JCAHO required it.

16 CO-CHAIR QASEEM: No, absolutely. I
17 agree with you that the assessment is going to be
18 done by nursing. What if you need to get
19 dieticians for consulting for any of these? It
20 is not going to be?

21 DR. STEIBER: Yes, -- no. So, the
22 assessment, actually I would argue, is

1 appropriately done by the dietitian. It is the
2 screening step that I believe is typically not
3 done by the dietitian. So, screening, then
4 assessment, and when they are at risk for
5 malnutrition, then they hand it over to a
6 dietitian and that is when that step occurs.

7 And I do believe that we do have
8 sufficient registered dietitian staffing in most
9 medical centers to handle the patients that are
10 screened as at-risk. However, certainly this
11 measure may shape that staffing ratio even
12 further.

13 CO-CHAIR QASEEM: And I think we can
14 -- if there are no other comments, I have a
15 really dumb question for you all. You are more
16 the experts than I am. How do you enter this in
17 an EHR in Epic, the screening, this information?
18 I am trying to figure out how will I enter it and
19 how will it get extracted.

20 MEMBER HILL: I can tell you how it is
21 done in my environment. And that is, it is a
22 checkbox on the admission assessment that

1 triggers an automatic referral to the nutrition
2 dietary department for them to look at that. And
3 then in our environment, the dietician will
4 screen the chart and date it to see if it is
5 truly worth the follow-up.

6 CO-CHAIR QASEEM: Because it was a
7 feasibility issue, others who might have
8 experience with this, how do you guys enter this
9 in your Cerner or Epic? Because in the EHR as
10 you write -- so, how are you going to enter the
11 information and then be extracted for someone to
12 be able to act on it?

13 MEMBER HILL: Well, I had experience
14 in Epic.

15 CO-CHAIR QASEEM: Oh, just Epic in
16 your hospital?

17 MEMBER HILL: I can't -- well, I have
18 experience in Allscripts, Epic, and MEDITECH.
19 And in all three of those --

20 CO-CHAIR QASEEM: It is the same?

21 MEMBER HILL: Yes.

22 MEMBER VENKATESH: It is the same.

1 CO-CHAIR QASEEM: All right, Arjun
2 same? All right. Sounds good.

3 Anything else?

4 MS. MCCAULEY: And just to follow-up,
5 after that registered dietician then gets that
6 information, there is further triage. So, it may
7 go to very specialized dieticians versus
8 generalists, versus technicians, as Alison
9 mentioned. We refer back to nutrition
10 assistance. So, we make sure that we really get
11 to those patients that have been assessed and
12 then we answer that consult.

13 CO-CHAIR QASEEM: Can we vote on
14 feasibility?

15 MS. CRAWFORD: Voting on Measure 3087,
16 feasibility. One, high; two, moderate; three,
17 low; four, insufficient.

18 And we have two high, twelve moderate,
19 two low, zero insufficient. So, 13 percent high,
20 75 percent moderate, 13 percent low.

21 DR. NISHIMI: Usability and use.

22 MEMBER BIALEK: Back to the issue of

1 getting the screening, not being specified for
2 the use of the validated tool, which is, again,
3 where all of the evidence seems to suggest is the
4 appropriate approach, I would say in terms of
5 accountability and performance improvement, this
6 really could not be used that way because of the
7 variability of the practice of screening in this
8 instance.

9 CO-CHAIR QASEEM: Any other comments,
10 Cathy?

11 MEMBER HILL: I would like to suggest
12 that we consider this -- can we consider this
13 measure as with one exception on the evidence?
14 Because I think that the evidence will improve
15 with --

16 DR. NISHIMI: We already passed it on
17 evidence. So, you wouldn't go back.

18 MEMBER HILL: Okay.

19 DR. NISHIMI: You would have to decide
20 -- you know basically, the final -- on the final
21 vote will need to make their own decision about
22 is it suitable for endorsement or not.

1 CO-CHAIR QASEEM: Okay, so seeing no
2 other comments, how about we vote on usability
3 and use, please?

4 Sure, go ahead.

5 MR. VALLADARES: So, one thing we did
6 want to highlight and, of course, it is a little
7 different under the purview, possibly, but the
8 particular measure set that you are looking at
9 today is actually part of a National Measurement
10 Quality Improvement Initiative that is being led
11 by multiple organizations, including the Academy
12 of Nutrition and Dietetics. Right now, the
13 actual strategy and plan for this initiative is
14 to expand the use of the measures and implement a
15 standardized malnutrition toolkit that actually
16 recommends validated screening tools. Right now,
17 there are about a subset of six to eight
18 hospitals that are beginning to pilot not only
19 the measures but also the toolkit. And the goal
20 is to expand it further. So, that is just
21 something to keep in mind, in terms of usability
22 that there is an actual, since the implementation

1 when we first tested the measures, sort of the
2 ball is moving forward with usability of this
3 measure with the hospitals. I just wanted to
4 share that.

5 DR. NISHIMI: Ron?

6 MEMBER BIALEK: I absolutely agree
7 with what you are saying. However, again, the
8 measure is not to use the validated tool. So,
9 you know the suggestion is that usability is
10 being demonstrated through these other means with
11 using the validated tool but that is not what
12 this measure is for.

13 The measure is for screening not for
14 validated screening.

15 MS. MCCAULEY: And just to narrow
16 that, we do have several facilities across the
17 country that do use validated nutrition screening
18 tool in their whole health systems. We
19 determine, and that is why we have several
20 studies that justify that use. I think when you
21 have the complexity and the difference in the QE
22 rate and the different conditions in the

1 hospital, we allow nursing and the dieticians
2 with the doctors and the pharmacists in
3 speech/language in that multidisciplinary team
4 that they are working with to determine what
5 those questions are going to be on that admission
6 item and what those checked boxes are.

7 Many times, because of the
8 specialization, there is core business at that
9 hospital, the dieticians may add a few more, the
10 nurses may want to have a few more questions.
11 Hence, that is why then they may take some of the
12 first two or three questions from the validated
13 score and tool but they will add a couple more
14 questions, just to make sure that they are
15 capturing what they need for those patients who
16 could be at risk in those certain conditions.

17 DR. NISHIMI: Emilio.

18 MEMBER CARRILLO: Yes, just kind of a
19 point of information in the question. CMS is now
20 spending a lot of time putting together a
21 screening for food and security as part of the
22 Accountable Health Communities Program. Is this

1 in sync with the work that you are doing or is
2 there any connection?

3 MR. VALLADARES: So, and I will let
4 Sharon actually follow-up because I am not 100
5 percent sure but I know that the work that we are
6 doing with malnutrition in general in a hospital
7 is very focused on the inpatient setting with
8 CMS, at this point. But the intention in the
9 next phase of the project is actually to expand
10 outside of the hospital care setting, since we do
11 know that elderly malnutrition is a community-
12 level issue. But this is sort of the start of
13 the rollout across the care setting continuum.

14 The other thing I did want to add, if
15 I may, if it is possible -- I'm not sure.

16 So, the other thing, this is just back
17 in -- and I want to put this into context with
18 the Joint Commission because I think this is
19 really important. So, the actual reasoning the
20 Joint Commission removed the standard of
21 nutrition screening within 24 hours from its
22 clinical standards is because they felt that it

1 was such a standardized process across all of
2 their accredited hospitals across the nation that
3 they felt that they could focus on something
4 else. However, the reason why we are bringing
5 this measure as a quality measure and focused on
6 accountability is the fact that, one, they
7 removed the standards. So, of course, now the
8 hospitals don't need to focus on it. So, we are
9 afraid -- so, there is always that understanding.

10 And then in the evidence attachment
11 that we presented, we showcase that study after
12 study proved that the actual risk, rate of
13 malnutrition, and then the eventual assessment
14 and findings of malnutrition don't balance out
15 with what is in terms of surveillance when you
16 look at ICD codes only. So, only claims
17 assessments of population surveillance, that
18 number is very, very highly underreported. And
19 so there are millions of cases of malnutrition
20 that are being left undiagnosed because there is
21 no systematic accountability now or really hasn't
22 been because not all hospitals need to follow the

1 standards every single day.

2 So, we know that the measure is the
3 best way for there to be data collection on the
4 process and so that is, in terms of usability, is
5 the argument in the case that we made today.

6 DR. NISHIMI: Arjun.

7 MEMBER VENKATESH: I just feel a
8 little nervous where we are on this usability
9 space and the role of an NQF Steering Committee
10 and the reason is this: technically, the measure
11 is not in use.

12 It is not being used right now. There
13 is no evidence of oh, in the presence of doing
14 the screening, we had this quality improvement.
15 It wouldn't meet the thresholds here. Where we
16 are at is in a space where, hey, the Joint
17 Commission has a -- we are climbing around this
18 and CMS wants a measure like this for the
19 Inpatient Quality Reporting Program. And so we
20 can choose to endorse this measure and say oh, it
21 has great usability potential because of the
22 Inpatient Quality Reporting program but then

1 those programs will turn around and say look,
2 this measure is NQF endorsed; it is a good
3 measure. And so you can kind of end up in this
4 cycle or circle of saying the potential for use
5 or the ability for the measure to actually drive
6 the development of a quality improvement agenda
7 is how endorsement is being used.

8 The risk there, though, is that we
9 then start endorsing measures or selecting
10 measures on criteria different than what is
11 originally set out. What is originally set out
12 is does it have an evidence base right now? Does
13 it have testing right now? Does it have
14 feasibility and usability right now?

15 And so this is -- I feel like it is a
16 real dangerous place to go to say oh, because
17 there is so much interest in the use or because
18 if we endorse the measure, the quality problem
19 will get solved is a dangerous place to go with
20 endorsement, I feel. In general, I feel like
21 there is other mechanisms in the measure and
22 policy space for that, the MAP, other things.

1 But I just want to bring that up
2 because people complain on the other side.
3 People say oh, why did this endorse measure of
4 lower evidence or why is CMS using this measure
5 in an IQR Program and CMS is going to say well,
6 it was NQF-endorsed. And so we are in that
7 circle.

8 MS. MUNTHALI: So, Arjun, you brought
9 up a good point. As part of our criteria, we
10 don't just ask for current use. We do ask for
11 planned use. And we expect that the next time
12 the measure is up for maintenance, there is
13 specific use, it has been implemented in
14 programs.

15 So, to the extent possible, if there
16 is any way you can, perhaps, update your
17 submission with what you have expressed to us and
18 what is missing in the submission, you would
19 definitely meet the criterion for that.

20 MR. VALLADARES: We can certainly do
21 that.

22 MS. MCCAULEY: And just a follow-up.

1 I know you had that question about population
2 health. Yes, that as we move forward, we have
3 already been working with CMS with IMPACT and all
4 the measures. And malnutrition is a huge issue
5 with their pressure ulcers, their readmissions,
6 and we want to make sure that we do move to post-
7 acute care and that is rehabilitation, long-term
8 care, hospitals, your home health, as well as the
9 skilled nursing facilities.

10 And so this measure is also being
11 looked at in that vein. And it is going to go
12 with our population health dieticians, community
13 nutritionists. It is going to move in that
14 spectrum.

15 CO-CHAIR QASEEM: So, let's vote.

16 DR. NISHIMI: Yes.

17 MS. CRAWFORD: Voting is open on
18 Measure 3087, usability and use. One high; two
19 moderate; three low; four insufficient
20 information.

21 Okay, we have zero high, eleven
22 moderate; five low; zero insufficient

1 information. So, 69 percent moderate, 31 percent
2 low.

3 DR. NISHIMI: Okay, we are ready to
4 vote on overall suitability for endorsement. So
5 this is the committee taking its entire
6 discussion on the measure. Voting on Measure
7 3087 --

8 MS. CRAWFORD: Oh, we can't -- no,
9 wait. I'm sorry, you had consensus not reached
10 on evidence.

11 DR. NISHIMI: Oh, on evidence! It was
12 so long ago. Sorry.

13 So, we can take a break for -- what is
14 the time?

15 CO-CHAIR QASEEM: Oh, no, no, no. We
16 are going to keep going.

17 DR. NISHIMI: Okay.

18 CO-CHAIR QASEEM: We are break but for
19 this measure we can move on. Right?

20 DR. NISHIMI: Okay, yes.

21 CO-CHAIR McINERNEY: Does that mean
22 that we will revisit this after the open

1 comments?

2 DR. NISHIMI: Yes.

3 CO-CHAIR QASEEM: Okay.

4 DR. NISHIMI: Sorry. It really was a
5 long time ago. I forgot about that one.

6 CO-CHAIR QASEEM: We can keep going.
7 Is that okay?

8 MS. MUNTHALI: Yes, lunch isn't here
9 yet. So, I would suggest we keep going.

10 CO-CHAIR QASEEM: So, they are not
11 going to feed us until we finish this. So, 3088,
12 Completion of Nutrition Assessment. Ron or
13 anyone want to take this on?

14 If you -- you are going to introduce
15 it but you will have to keep it within one
16 minute.

17 DR. NISHIMI: Anything that is new.

18 CO-CHAIR QASEEM: Go for it. Your
19 clock starts.

20 MS. MCCAULEY: So our next measure
21 submitted for your review is fully specified for
22 use with EHRs measuring the proportion of

1 nutrition assessments completed for patients at-
2 risk of malnutrition identified by a completed
3 malnutrition screening.

4 So, this is NQF 3088. Nutrition
5 assessment is recommended for patients who are
6 identified to be at-risk for malnutrition by
7 screening. This measure focused on elderly
8 patients, age 65 years and older who are
9 specifically at higher risk for malnutrition due
10 to more prevalent comorbidities such as COPD,
11 dementia, orthopedic conditions, and some forms
12 of cancer.

13 A 2014 study by Snider, et al of all
14 the burden of malnutrition on elderly in the
15 United States demonstrated the prevalence of
16 malnutrition in the hospital is as high as 38.7
17 percent. The completion of a nutrition
18 assessment using a recommended assessment tool,
19 such as our nutrition-focused physical exam or a
20 subjective global assessment provides the
21 opportunity for a registered dietitian to assess
22 the patient for physical findings of

1 malnutrition.

2 This process allows for a malnutrition
3 diagnoses and also informs the development of a
4 nutrition care plan and includes the proper
5 evidence-based intervention for the patient,
6 based on their assessment needs and results.

7 CO-CHAIR QASEEM: Thank you. Ron or
8 Cathy? Any comments? Any general comments?

9 Oh, is it --

10 DR. NISHIMI: Arjun.

11 CO-CHAIR QASEEM: Oh, it is Arjun.
12 Sorry about that. Sorry.

13 DR. NISHIMI: Oh, yes, Arjun and
14 Cathy, still.

15 MEMBER VENKATESH: This is just the
16 next step in the measure in the sense that if the
17 denominator obviously used if you screen positive
18 and are identified as at-risk for malnutrition,
19 then was a structured assessment done.

20 I think we discussed I think the
21 structured assessment enough before. There was
22 broad agreement in that kind of any of the tools

1 is probably a meaningful way to do this.

2 For the evidence, itself, I think that
3 there is a -- I think generally this is either
4 probably a moderate, based on the fact that there
5 is a clinical practice guideline with Grade C
6 evidence or it could probably also might fall in
7 that bucket of insufficient with exception,
8 meaning that there is a good international or
9 national consensus statement that supports the
10 activity without the evidence.

11 I mean that is probably the better
12 place for this because there a systematic review
13 that said that included studies that there was
14 limited evidence within those. Part of that
15 probably has to do with the things you guys spoke
16 about, the quality of the evidence earlier on.

17 And so I think it is either moderate
18 or insufficient. I think either way, from an
19 evidence perspective it probably moves forward in
20 evaluations.

21 CO-CHAIR QASEEM: Cathy, do you have
22 any comments?

1 And so we are getting into the
2 evidence piece. Is it okay if we continue with
3 the evidence?

4 DR. NISHIMI: Evidence?

5 CO-CHAIR QASEEM: Yes. Any other
6 comments?

7 So, I have got a few comments. Again,
8 I reviewed this measure a while ago, so I am
9 going to be trying to be looking at it again.
10 So, you do talk about, of course, there is
11 variation in screening. There is no argument. I
12 absolutely agree with you.

13 There is the variation in treatment of
14 malnutrition, it is presumed in the document
15 throughout. I did not see any evidence that
16 there is variation in treatment. I am talking
17 about the evidence piece. Okay? I know what is
18 happening out there. That is different. But if
19 you are going to look into the evidence, that is
20 one issue.

21 Because you cite the evidence for this
22 measure, which is a 2011 guideline by American

1 Society of Parenteral and Enteral Nutrition,
2 which states that nutrition support intervention
3 is recommended for all patients identified by
4 screening assessment at risk for malnutrition,
5 malnourishment. This is rated as a Grade C
6 recommendation.

7 Once I started digging into the
8 evidence, and your point taken in terms of the
9 issues with the observation and randomized
10 trials, the guideline is based on three small
11 randomized controlled trials and one
12 nonrandomized cohort study with historical
13 controls, and one nonrandomized cohort with some
14 issues as well.

15 And although I think this measure
16 starts getting better compared to the other one
17 that we just talked about, my concern is that
18 there was significant biases that were very
19 evident in this clinical practice guidelines, as
20 well as the systematic review that was done. The
21 risk of bias was very, very high. So much so
22 that evidence is being used to behind this but

1 the evidence itself is -- I would caution the
2 evidence that was presented.

3 And then evidence is a little bit
4 inconsistent that screening leads to referral for
5 nutritional intervention but I am not going to
6 talk too much about evidence. The bottom line is
7 I had some concerns in terms of the guideline and
8 the evidence that was presented as the basis for
9 this recommendation.

10 DR. NISHIMI: Any other committee
11 comments?

12 MR. LYNCH: If I could just get you to
13 clarify. When you are talking about the concerns
14 you have, do you have any concerns about the
15 implementation of interventions?

16 CO-CHAIR QASEEM: The evidence that
17 was presented as basis for nutritional assessment
18 for this measure. Evidence that forms the basis
19 for this measure has got a lot of red flags.

20 That is why I actually went into the
21 evidence, so you guys have it and you can look it
22 up in terms of the evidence that you talk about

1 it. I listed the studies that is used. That is
2 why, just to make sure, I really went into each
3 guideline and systematic review that was used as
4 evidence as basis for this measure.

5 So, not only those studies were
6 questionable, the risk of bias, the risk of bias
7 of the guideline by itself was, at least to my
8 knowledge and my experience, I would classify it
9 as very high.

10 MEMBER STIEFEL: Can you elaborate on
11 the risk of bias?

12 CO-CHAIR QASEEM: So risk of bias,
13 essentially bottom line is the evidence that was
14 presented, those individual four studies that is
15 based on, they went above and beyond what those
16 studies were saying in terms of the folks who
17 were on the panel who develop these guidelines.
18 I would caution a little bit that some bias is
19 related to that.

20 Of course, it is always the case with
21 many of the guidelines. We all know that. But I
22 was getting a little I think some red flags that

1 just kept on going up. One or two I am okay but
2 when in order of the things you need to develop a
3 good clinical practice guidelines, when one, two,
4 three, four, five occur each of them, without
5 getting into too much detail, started going up, I
6 started getting worried that if there is even
7 enough evidence to support this measure.

8 DR. NISHIMI: Marcel and then -- okay.

9 MEMBER SALIVE: So, I think I am going
10 to go out of order again. I think the next one I
11 have -- and I think by going in this order, we
12 are kind of losing the forest to the trees. The
13 next one it talks about nutrition care plan and
14 talks about an intervention.

15 So, I think when you talk about
16 screening and getting a diagnosis, you can get
17 very narrowly focused on that. But the big
18 picture on screening is generally to do that
19 screening, get the diagnosis, make the
20 intervention, and improve health outcomes. And
21 so maybe you are right. I don't know. To me,
22 six studies with a low risk of bias is actually a

1 lot.

2 But I looked at the other, the next
3 one and there are -- you know I guess this
4 guideline looks very feeble but there is a
5 Cochrane Review on nutritional supplements for
6 people who are malnourished that is very strong,
7 I think, and says there are interventions for
8 these people that do improve health outcomes and
9 has over 10,000 patients. And there is also a
10 recent randomized trial that is not in there that
11 has another 600 people.

12 So, to me, the benefits are important
13 to consider there and you know I think it goes
14 together. And so you know that measure -- I felt
15 the evidence for that measure is sufficient,
16 moderate, whatever you want to call it.

17 And so here we are kind of in the
18 middle and we can discuss the evidence on this in
19 the middle. But really, the big picture is where
20 they get the diagnosis, they get some
21 supplementation, something happens, and you
22 improve health outcomes. So, reduced

1 complications, improved health outcomes. I saw
2 that and I was fairly happy with that evidence.

3 CO-CHAIR QASEEM: So, just to respond
4 and Arjun, I will come to you, I did look at some
5 of the other studies and trials as well.

6 So, the evidence, to my knowledge --
7 again correct if I am wrong. I looked at it, of
8 course, as quickly as I could because I had a lot
9 of measures to review. Evidence is focused on
10 UTIs, pressure ulcers, falls, fractures, acute
11 respiratory tract infection in those elderly
12 patients. That is the trial that you are
13 referring to.

14 You are not looking at, again, keep it
15 in mind you are looking at beyond that right now.
16 So, that is what my --

17 MEMBER SALIVE: No, I think the
18 Cochrane Review had 24 trials and it wasn't just
19 those patients that you are talking about. So,
20 there was broader -- there were multiple other.

21 CO-CHAIR QASEEM: Arjun?

22 MEMBER VENKATESH: Just so I have it

1 right, we are doing 88 right now, right? Okay,
2 so for 88, I opened up the guideline, the 2011
3 one that is cited. There is one inaccuracy I
4 think we should be aware of. This is -- what we
5 are reading in the measure worksheet says that it
6 was graded Grade C. In the actual guideline, the
7 nutrition assessment is Grade E. What is Grade C
8 is the intervention.

9 And so, just so we are clear, what is
10 in the guideline specific to the measure, is
11 Grade E, which is the lowest level grading.

12 CO-CHAIR QASEEM: Thanks, Arjun.

13 MS. MCCAULEY: Alison Steiber wanted
14 to respond. Alison?

15 DR. STEIBER: Hello. I apologize.
16 I'm in a little bit of a noisy space here but I
17 just wanted to talk about the risk of bias issue
18 that was brought up.

19 You know so when that study was done,
20 there was not a real validated tool for risk of
21 bias for nutrition studies. So, while I agree
22 that certainly it is important to assess risk of

1 bias and certainly the grade methodology
2 indicates that, I actually think that that is a
3 bit of a limitation, as it relates to our studies
4 and how we grade nutrition in systematic review.

5 And so I think we have to, instead,
6 look at the more preponderance of information as
7 it relates to this topic and the fact that there
8 are quite a bit of studies that show improvements
9 in outcomes with nutrition intervention, even if
10 we don't have the grade level the way we would
11 like it to.

12 And I think newer systematic reviews
13 will do that, as we get better and better at
14 assessing risk of bias in nutrition.

15 CO-CHAIR QASEEM: Thanks, Alison.

16 Any other comments on evidence?
17 Anyone who is disagreeing with what we talked
18 about, in terms of evidence?

19 DR. NISHIMI: So, I just want to
20 clarify. The submission referred to part of the
21 guideline and said Grade C. And Arjun has looked
22 up the guideline and made reference to a

1 different part of it, referring to Grade E, which
2 is substantially different from C, obviously.

3 So, what is the developer's position
4 on what is the applicable guideline and,
5 therefore, grade?

6 MR. VALLADARES: Thank you for that
7 clarification. I think looking at the guideline
8 or so myself, I think we did include the
9 incorrect guideline recommendation. So, it
10 should be nutrition assessment is suggested for
11 all patients who were identified to be a
12 nutrition risk by nutrition screening and that
13 grade level is E.

14 DR. NISHIMI: Okay I just wanted to
15 clarify it for everyone.

16 MR. VALLADARES: Thank you for that
17 clarification.

18 CO-CHAIR QASEEM: Thanks so much,
19 Arjun.

20 So, let's vote on evidence, please.

21 MEMBER SALIVE: Can I just say one
22 last thing? Because I think that the other thing

1 to consider is just the risk of harm from this
2 labeling. And that, I think, is extremely low in
3 this instance also.

4 So, maybe the evidence is low but that
5 is another consideration for screening is the
6 risks of harm. And I don't see any evidence of
7 that.

8 CO-CHAIR QASEEM: So but that was
9 taken into account when they come out with the
10 guideline recommendation as E. They look at
11 benefits and harms, right? Except labeling, they
12 might have looked at it.

13 Did they look at the labeling in that
14 guideline, do you know? I mean you looked at all
15 of the benefits and harms and then decided on
16 what you are going to give it as a grade.

17 MEMBER SALIVE: It is not related.

18 CO-CHAIR QASEEM: Okay, so let's just
19 vote.

20 MS. CRAWFORD: Voting on Measure 3088,
21 evidence. One, high; two, moderate; three, low;
22 four, insufficient.

1 One more vote.

2 MS. OGUNGBEMI: Mike, are you still
3 with us?

4 MEMBER BAER: Yes, I did send one. I
5 will send it again. Did you get it?

6 MS. CRAWFORD: Okay, so, zero high,
7 eight moderate, five low, three insufficient.
8 So, 50 percent moderate, 31 percent low, 19
9 percent insufficient.

10 So, it is consensus not reached. So,
11 we will go on to discuss and vote on gap.

12 CO-CHAIR QASEEM: Any discussion on
13 gap? Arjun, Cathy, anything?

14 MEMBER VENKATESH: So, I think they
15 had some survey data that showed evidence of a
16 gap. I don't think that there was testing data,
17 necessarily, on the gap. But there was, I think
18 the exact figure was 23 percent of the time out
19 of a 1700-person survey was a structured
20 assessment tool used.

21 So, it is a little tricky to apply
22 because it is provider level not a patient level.

1 But I imagine that it feels right in terms of
2 there being a gap in the use of a structured
3 assessment tool.

4 CO-CHAIR QASEEM: Okay, seeing no --
5 well, we can probably vote on this one. No other
6 comments? All right, let's vote.

7 MS. CRAWFORD: Voting on Measure 3088,
8 performance gap. One, high; two, moderate;
9 three, low; four, insufficient.

10 We have three high, eleven moderate,
11 one low, zero insufficient. It is 20 percent
12 high, 73 percent moderate, 7 percent low.

13 DR. NISHIMI: So, we should go on to
14 discussing the validity and reliability testing.

15 MEMBER VENKATESH: So, they have got
16 some EHR reliability testing done that shows that
17 this can be specified in the EHR, that these data
18 elements are captured, as well as related
19 validity testing with chart abstraction.

20 I guess I am in a spot where -- and I
21 don't know if this is out of order to ask the
22 question but I feel like this measure could get

1 NQF endorsement if, on the first question,
2 everybody totally understood like the opportunity
3 to say that you can rate it as insufficient
4 evidence but with exception because they are
5 probably going to meet our standards with respect
6 to reliability, validity and all these things
7 down the line.

8 And so the real question -- the way
9 the voting goes is when you get like moderate,
10 low, and then some insufficients, you end up with
11 yes, no consensus. But it is not a true like
12 three-way branch point, like a low, medium and
13 high is.

14 And so I am just wondering if we are
15 kind of doing a disservice to this measure by not
16 fully kind of giving it that insufficient with
17 exception evaluation. Because then all these
18 subsequent things are very different.

19 DR. NISHIMI: I mean the committee
20 could, I think, at least decide not to continue
21 discussing these elements and wait until the
22 post-comment call when you settle the evidence

1 question and then continue down. That is an
2 option.

3 MEMBER HILL: But we don't have the
4 exception option?

5 DR. NISHIMI: No, you would reconsider
6 starting at the top because you did not reach
7 consensus on it. So, that is an option to just
8 stop discussing this one, which is, I think what
9 Arjun is suggesting.

10 MS. MUNTHALI: How many -- I would
11 like to get a sense from the rest of the
12 committee if you feel the same way that Arjun
13 does and would like to stop or -- I mean if there
14 is significant concern about your initial vote on
15 evidence, maybe we revisit that. But I just want
16 to get a sense from everyone on what their
17 feelings are, their thoughts on this.

18 A show of hands. So, did you agree
19 with what Arjun had just stated?

20 CO-CHAIR QASEEM: Yes, how many of you
21 are like Arjun?

22 MEMBER SELLERS: I'm sorry to do this

1 but because I stepped out for a second, can you
2 recap what you said quickly?

3 MEMBER VENKATESH: Sure, what I was
4 just saying was that when we vote like medium,
5 low, and insufficient, it creates this kind of
6 false three-way thing, where really the first
7 question should just be insufficient or not. And
8 if we chose -- my guess is that some of the
9 people who voted low might have actually chosen
10 insufficient.

11 So, if those people who actually
12 chosen first insufficient, we would then not
13 would have voted to rate it high, medium, or low,
14 we would have voted to rate insufficient with
15 exception or not.

16 And I think this is actually the kind
17 of thing that falls in that category, because
18 there is not evidence. There is an expert
19 consensus statement. There is not another rule
20 measure out there. And we could have had a
21 discussion about the risks. Is it on balance?
22 Is this worth moving forward when there is an

1 expert consensus statement, in the absence of
2 evidence.

3 But instead, we do this weird thing
4 where we vote between low, medium and
5 insufficient and so we ended up with this kind of
6 smattering of votes between the three that
7 doesn't allow us to go down that road at all.

8 And so I guess the question would be
9 do you want to -- I guess I can make two
10 proposals. Proposal one is we could vote on
11 whether or not you would consider insufficient
12 with exception. And if overall, there is some
13 group consensus for that, maybe we can defer to
14 the post-call. Or to just vote insufficient or
15 not. And if a lot of people -- if there is
16 consensus on insufficient, then you can always
17 have the exception vote after.

18 MS. MUNTHALI: Yes, so Arjun, I just
19 wanted to clear up something. You did follow the
20 process. What we probably should have clarified
21 is that if you did vote insufficient, then it
22 takes down that path. But you have to have those

1 four options there.

2 But I don't know if we sensed that
3 that is where the committee wanted to go
4 generally, that you were thinking that it is not
5 that the evidence was low, it is just that we
6 didn't have sufficient evidence. And then, that
7 would have given you the option of an
8 insufficient with exception.

9 So, I guess the question could be
10 maybe we just revote on that, knowing that like
11 what we did yesterday to be consistent with the
12 process, if you want the insufficient with
13 exception pathway, you must have 61 percent of
14 the committee voting at insufficient; not low,
15 but insufficient.

16 DR. NISHIMI: Because we did have
17 moderates and lows. And so it was all spread
18 out.

19 So, let's see a show of hands if the
20 committee wants to revote on evidence.

21 CO-CHAIR MCINERNEY: No. I mean I
22 think we had a good vote on evidence and a good

1 discussion. So, you know I know we are in
2 Washington, D.C. and certainly Congress is prone
3 to revote, and revote, and revote but let's not
4 follow their example.

5 DR. NISHIMI: Anyone else?

6 MS. MUNTHALI: We saw a couple of
7 hands but don't see too many.

8 DR. NISHIMI: Okay. So, then
9 consensus is not reached on evidence. We will
10 come back, obviously we have to come back to
11 revisit because we are not going to vote on
12 overall suitability for endorsement.

13 The additional question that Arjun
14 raised was whether this pathway, whether we
15 should discuss now validity, reliability,
16 usability and feasibility, or whether you want to
17 hold that for a post-comment call. That was the
18 second proposal he made.

19 So, let me ask for this. Show of
20 hands to stop discussion.

21 MEMBER MOLINE: I would like to just

22 --

1 DR. NISHIMI: Okay.

2 MEMBER MOLINE: I would just like to
3 -- let's complete this thought process, rather
4 than losing this train of thought for a post-
5 call, if we can do this in a reasonable time
6 frame.

7 DR. NISHIMI: Okay, I don't see any
8 groundswell to suspend this measure. So, then
9 let's continue with scientific acceptability of
10 the measure properties. So, we are discussing
11 reliability of the specifications, testing, and
12 then the validity, which obviously goes to
13 evidence.

14 CO-CHAIR QASEEM: Any more discussion
15 on reliability and validity? I think we can do
16 those two together, to a certain degree and then
17 vote on two together. I mean both separately.

18 Any discussion on reliability and
19 validity? None. Let's vote.

20 MS. CRAWFORD: Voting is open on
21 Measure 3088, reliability. One, high; two,
22 moderate; three, low; four, insufficient.

1 DR. NISHIMI: Actually, I'm sorry.
2 The highest eligible rating here is moderate.
3 Okay? So, the highest -- so, one, moderate; two,
4 low; three, insufficient because they did data
5 element level.

6 MS. CRAWFORD: You started voting?
7 Okay.

8 CO-CHAIR QASEEM: Is that okay?

9 MS. CRAWFORD: That's fine, as long as
10 we get 16 votes.

11 DR. NISHIMI: So, if you were voting
12 on the other one, just re-press based on the one,
13 two, three. It will re-record your new vote, so
14 to speak.

15 MS. CRAWFORD: Okay, we have our 16.
16 Okay, we have 13 -- oh, there is that. Well, I
17 counted 16 -- they haven't voted yet?

18 Let's redo, just in case the two votes
19 that were cast earlier we couched on this slide.
20 So, if we could redo it one more time.

21 Okay, it's open. One, moderate; two,
22 low; three, insufficient.

1 Okay, we have a total of 17 votes.

2 Okay? All right, perfect. Fourteen moderate,
3 three low, zero insufficient. So, 82 percent
4 moderate, 18 percent low.

5 DR. NISHIMI: So, we will do validity.
6 Again, the same thing. The high is not eligible.

7 MS. CRAWFORD: One is moderate, two is
8 low, three, insufficient.

9 Okay, we have twelve moderate, three
10 low, two insufficient. So, 71 percent moderate,
11 18 percent low, 12 percent insufficient.

12 CO-CHAIR QASEEM: So, we continue on
13 feasibility?

14 DR. NISHIMI: Yes, feasibility.

15 CO-CHAIR QASEEM: Feasibility. Arjun,
16 Cathy, anyone, actually.

17 MEMBER VENKATESH: No concerns. I
18 think we have talked about this before. I think
19 you have got the EHR data specified --

20 CO-CHAIR QASEEM: By the time you get
21 here, you can just do it anyway.

22 MS. CRAWFORD: Voting is open for

1 feasibility. One, high; two, moderate; three,
2 low; four insufficient.

3 We have one high, fifteen moderate,
4 one, low. So, 6 percent high, 88 percent
5 moderate, 6 percent low.

6 DR. NISHIMI: Okay, usability and use.

7 MS. CRAWFORD: Voting is open.
8 Measure 3088, usability and use. One, high; two,
9 moderate; three, low; four, insufficient
10 information.

11 Okay, we have zero high, fourteen
12 moderate, three low, zero insufficient
13 information. So, zero percent high, 82 percent
14 moderate, 18 percent low, zero percent
15 insufficient information.

16 CO-CHAIR McINERNY: And so we revisit
17 this, then, after the open comment period to try
18 and resolve our consensus not reached on
19 evidence. Correct?

20 MS. CRAWFORD: Yes.

21 CO-CHAIR McINERNY: Thank you.

22 CO-CHAIR QASEEM: Do you want to take

1 a lunch break or do you want to just ask how does
2 everyone want to proceed?

3 MS. MUNTHALI: Well, I think we can do
4 a 15-minute lunch break and that puts us back on
5 schedule. So, we come back at 1:15.

6 CO-CHAIR QASEEM: A working lunch?

7 CO-CHAIR McINERNEY: Working lunch.

8 MS. MUNTHALI: Working lunch.

9 CO-CHAIR QASEEM: But our measure
10 developer folks, you will be able to stay?

11 MS. MUNTHALI: And we also neglected
12 to ask if there are any public comments.

13 Operator, if you can open up the lines
14 for the members of the public that are listening
15 in that have a comment and anyone in the room who
16 may have a comment on any of the measures we have
17 reviewed.

18 OPERATOR: Okay, if you would like to
19 make a comment, please press star and the number
20 1. You do have a public comment from Meredith
21 Ponder.

22 MS. MUNTHALI: Hello.

1 MS. PONDER: Hi. Can you hear me?

2 MS. MUNTHALI: Yes, we can. Please go
3 ahead.

4 MS. PONDER: Okay, great. Hi, I am
5 commenting on behalf of Defeat Malnutrition
6 Today, which is a coalition of over 40
7 organizations and stakeholders and we share the
8 goals of achieving the recognition of
9 malnutrition as a vital sign of older adult
10 health and we are working to achieve a greater
11 focus on malnutrition screening and intervention.

12 And we would like to say that older
13 adults are at high risk of becoming malnourished
14 and under nourished due to chronic illness,
15 disease, injury, or social determinants, which
16 makes it harder for them to recover from surgery
17 and illness, makes it more difficult for their
18 wounds to heal, increases their risk for
19 infections and falls, and decreases their
20 strength that they need to take care of
21 themselves. And their health costs can be 300
22 percent greater than those who are not

1 malnourished on entry to the healthcare system.

2 And we support NQF endorsement for
3 these four malnutrition quality measures, as it
4 is critical to ensure that malnutrition is
5 identified, treated, and that patient nutritional
6 status is documented as a diagnosis in the
7 patient's medical record to ensure prompt
8 nutrition intervention and continuity of care for
9 older adults upon discharge to home or post-acute
10 care settings.

11 MS. MUNTHALI: Thank you.

12 CO-CHAIR McINERNY: Thank you for your
13 comment.

14 MS. PONDER: Thank you.

15 DR. NISHIMI: Okay, I think we are
16 ready to take a 15-minute break to go get the
17 lunch and bring it back and we will have -- the
18 rest of it will be a working lunch.

19 CO-CHAIR McINERNY: We need to keep
20 well-nourished.

21 (Whereupon, the above-entitled matter
22 went off the record at 12:59 p.m. and resumed at

1 1:20 p.m.)

2 MS. MUNTHALI: Okay, we're going to
3 get started. And what we are doing right now is
4 Yetunde is going around to our new committee
5 members, Matt and Steve and Barry-Lewis, in
6 absentia, Ann DeBiasi, we are going to pick the
7 next terms for the committee. And when she is
8 done with that, we will get started with review.

9 MS. OGUNGBEMI: If you could say your name and
10 announce your choice, please. Thank you.

11 Oh, I had the newest committee members
12 pick terms. So two or three years. Yes.
13 Choice, yes. No switching.

14 MEMBER STIEFEL: And what are we
15 supposed to do?

16 CO-CHAIR McINERNEY: Read the number.

17 MEMBER STIEFEL: Three.

18 DR. NISHIMI: Matt Stiefel, three.

19 And then Steve.

20 MEMBER TEUTSCH: Three.

21 (Simultaneous speaking.)

22 MS. OGUNGBEMI: There were an even

1 number of choices.

2 (Simultaneous speaking.)

3 MS. OGUNGBEMI: I picked for our other
4 new committee member Anne De Biasi and she got
5 two years. Thank you.

6 MEMBER MOLINE: Can I ask how do we
7 know when our terms end? Because I can't
8 remember when it was that we pulled the short end
9 or long end, however we want to call it.

10 When we decide if it's feasible or
11 usable?

12 MS. MUNTHALI: What we'll probably do
13 is follow up with you after this meeting. We're
14 tracking your terms and we'll let you know where
15 you are and which one you picked.

16 I can't remember which you picked, but
17 you're good for now.

18 DR. NISHIMI: Okay, we're going to
19 proceed with our next measure if the developers
20 can very briefly introduce their measure and then
21 the committee will start discussing them.

22 If the comments are similar to what

1 you made, or exactly what you made for the other
2 ones if you could be very brief about it so that
3 hopefully we've discussed most of the issues with
4 these measures and we'll be able to move through
5 quickly.

6 MS. MCCAULEY: Okay, thank you. So
7 this measure is 3089 and it is an eMeasure
8 hybrid, partially specified for use with EHRs and
9 partially requiring chart-abstracted measure
10 data.

11 Again, this is for patients age 65 and
12 older.

13 The nutrition care plan contains the
14 registered dietitian's recommended approach for
15 intervening on the patient's malnutrition.

16 The findings from the nutrition
17 assessment serve as the basis for determining the
18 appropriate way to address the patient's
19 condition.

20 The measure is not oriented toward a
21 specific intervention, but rather a process
22 whereby the assessments and interventions are

1 organized for implementation through a
2 recommended plan of care.

3 As of late 2015 the majority of states
4 have specific statutory or regulatory impediments
5 that exist and preclude registered dietitian
6 nutritionists from taking full advantage of
7 ordering writing privileges.

8 And the CMS expanded that role for
9 dietitians, but state by state we have to then
10 make sure that that's implemented. And so that
11 has hindered in some of the automatic
12 interventions and ordering that need to be done.

13 The 2014 study of malnutrition care
14 practices in the United States showed only one
15 quarter of the surveyed clinicians in the United
16 States reported whether nutrition assessment
17 informed the determination of a malnutrition
18 diagnosis.

19 The results of the study represented
20 a downstream gap in care for determining the
21 appropriate nutrition care plans as the findings
22 of a nutrition assessment completed by a

1 registered dietitian inform such a plan of
2 nutrition intervention for malnourished patients.

3 Thank you.

4 CO-CHAIR QASEEM: Okay. Comments on
5 this measure.

6 MEMBER SALIVE: So, I said earlier
7 what I said, but I'll repeat that it was very
8 good, I thought, that they had not just the
9 guideline, but a Cochrane Review which had many
10 trials supporting the supplement.

11 The nutritional supplement to these
12 malnourished people does improve several
13 different health outcomes.

14 So, I thought this evidence spanned
15 the full workflow that they outlined, and that it
16 was strong.

17 CO-CHAIR QASEEM: Other comments? So,
18 I see what you're saying, Marcel.

19 When I looked at this measure quickly,
20 at least the evidence that's presented by the
21 measure developers, and please correct me if I'm
22 wrong. And Alison, hopefully you're still on the

1 phone as well.

2 The performance gap, I'm going to go
3 through all of the comments together because
4 we're going to probably move quickly through it.

5 It's from a paper that was published
6 in 2008. So, I am not really sure why the
7 measure developers did not look at any newer data
8 when they were talking about the performance gap.

9 Again, as I said I'm going to cover
10 all of my comments together so we can keep the
11 process moving.

12 And the same paper also showed that
13 the patients who had this assessment were more
14 likely to get additional feeding and vitamins,
15 but they did not report any difference in
16 outcomes.

17 It includes a level C recommendation
18 and that's based on a systematic review that was
19 again in the seven or eight years ago for which
20 the data was collected between 1986 and 2005. So
21 you're looking at almost 11 years old the latest
22 data that was used in this one. Just a few

1 general comments.

2 So, I understand what you're saying,
3 and since we're not discussing Cochrane, because
4 I don't want to waste committee's time because I
5 know that evidence as well. I've looked at
6 Cochrane Review.

7 But based on what you have presented
8 in the -- I'm just curious why are we going that
9 far back for gap data as well as for evidence.

10 Even the gap is from 2008.

11 MR. VALLADARES: So, we again used the
12 Cochrane data to support our evidence submission,
13 our evidence attachment.

14 And unfortunately the most recent
15 broader guideline that is supported through some
16 of the largest professional societies is that
17 ASPEN systematic guideline.

18 And then the only other recent
19 evidence is not systematic. It's the consensus
20 statement. So, that's basically the most recent
21 data that there is available at a systematic
22 level.

1 MEMBER SALIVE: There was a 2016 trial
2 which I mentioned earlier also. So I think
3 there's some more recent evidence.

4 I think nutrition trials span the
5 whole spectrum of duration. There's some older
6 ones and newer ones.

7 I agree though about the gap, that
8 that evidence was scant. But I believe there is
9 a gap.

10 CO-CHAIR QASEEM: Other comments?
11 Okay, how do you want to go about doing this?
12 Shall we just go through the comments quickly
13 about it in general and just vote on it, or just
14 go through each step?

15 DR. NISHIMI: Yes, I think you just
16 need to move to -- so, evidence. If there are
17 any other committee members that want to address
18 evidence or gap. Otherwise we'll vote on both.

19 CO-CHAIR QASEEM: Let's vote.

20 MS. CRAWFORD: Voting is open on
21 measure 3089. One - high, two - moderate, three
22 - low, four - insufficient.

1 We have 1 high, 14 moderate, zero low,
2 1 insufficient. Six percent high, 88 percent
3 moderate, zero percent low, 6 percent
4 insufficient.

5 DR. NISHIMI: Performance gap. Ready
6 to vote.

7 MS. CRAWFORD: Voting is open on
8 measure 3089, performance gap. One - high, two -
9 moderate, three - low, four - insufficient.

10 We have 1 high, 11 moderate, 1 low, 2
11 insufficient. That's 7 percent high, 73 percent
12 moderate, 7 percent low, 13 percent insufficient.

13 DR. NISHIMI: Scientific
14 acceptability, reliability and validity testing.
15 They did data element so it will ultimately be
16 eligible only for the moderate rating.

17 But was there anything different about
18 this measure that the committee members who
19 reviewed it want to make a comment on?

20 MEMBER MINNICH: I would just add
21 that, again, it was tested across three different
22 EMR systems and two different sites.

1 DR. NISHIMI: Did you want to expand
2 on whether you thought that met the reliability
3 or validity --

4 MEMBER MINNICH: I believe that it
5 did, yes.

6 DR. NISHIMI: Okay. Any other
7 comments on validity and reliability? Arjun,
8 Amir.

9 MEMBER VENKATESH: I think they did
10 basically data element reliability that has
11 adequate agreement. The kappas are lower
12 probably because the samples are smaller and so I
13 would give it moderate.

14 DR. NISHIMI: Okay.

15 MS. CRAWFORD: Voting is open on
16 measure 3089 reliability. One - moderate, two -
17 low, three - insufficient.

18 We have 10 moderate, 5 low, zero
19 insufficient. Sixty-seven percent moderate, 33
20 percent low, zero percent insufficient.

21 CO-CHAIR QASEEM: Any comments?

22 DR. NISHIMI: That was just

1 reliability.

2 CO-CHAIR QASEEM: Oh, sorry. I'm
3 ahead.

4 DR. NISHIMI: Any other comments on
5 validity? Arjun?

6 MEMBER VENKATESH: What are the
7 standards for this for an eMeasure that's kind of
8 in the works? Because they only have two sites.
9 And so I don't know for sure -- the main one that
10 I always care about in validity is can you make
11 meaningful inferences about quality between two
12 different facilities based on the score.

13 They have testing data from two sites
14 that is different. That doesn't mean that you
15 can actually detect meaningful differences, but
16 that may be an undue expectation for an eMeasure
17 that doesn't have a bunch of testing data that
18 would do it.

19 And so --

20 DR. NISHIMI: The eMeasure requirement
21 was at the two sites. But the committee could
22 decide that, you know, you want a higher

1 threshold.

2 But the minimum for purposes of
3 eMeasure feasibility is really what it goes to,
4 not the question of whether there's a meaningful
5 difference.

6 MEMBER VENKATESH: Gotcha.

7 MEMBER HILL: So can we clarify
8 whether the hospice exclusion is included or
9 excluded of the -- with regards to the final
10 specifications.

11 MR. VALLADARES: Great, thank you for
12 that question.

13 So, in this particular measure
14 following along sort of that logic that I shared
15 earlier there was a significant difference in the
16 results for both the data element and the
17 performance score level when the patients that
18 met exclusion criteria were excluded.

19 So, in this measure the specifications
20 do exclude all of those patients that we -- so it
21 was the hospice, discharge against medical
22 advice, and also length of stay under 24 hours.

1 DR. NISHIMI: Any other questions or
2 comments? Okay, ready to vote on validity.
3 Moderate, low and insufficient are your options.

4 MS. CRAWFORD: We have nine moderate,
5 seven low, zero insufficient. Fifty-six percent
6 moderate, 44 percent low.

7 DR. NISHIMI: So, consensus is not
8 reached on the validity and we'll continue to
9 discuss feasibility and usability and use, but
10 we'll hold the final vote until after comments
11 are received on the post-comment call where you
12 will review those comments on then vote on the
13 post-comment call.

14 CO-CHAIR QASEEM: Any comments on
15 feasibility?

16 DR. NISHIMI: I just want to clarify
17 for the committee this is different because it
18 involved chart review as well as EMR.

19 CO-CHAIR QASEEM: That's okay. I
20 mean, it's just -- you know what I'm going to say
21 about EHR review.

22 MS. CRAWFORD: Okay, voting is open

1 for measure 3089 feasibility. One - high, two -
2 moderate, three - low, four - insufficient.

3 We have five high, nine moderate, two
4 low, zero insufficient. Thirty-one percent high,
5 56 percent moderate, 13 percent low, zero percent
6 insufficient.

7 DR. NISHIMI: Okay, usability and use. Any
8 committee comments? Okay, we can vote on
9 usability and use.

10 MS. CRAWFORD: One - high, two -
11 moderate, three - low, four - insufficient
12 information.

13 We have 2 high, 11 moderate, 2 low, 1
14 insufficient information. Thirteen percent high,
15 69 percent moderate, 13 percent low, 6 percent
16 insufficient information.

17 DR. NISHIMI: And we won't vote on
18 this measure until the post-comment call. So
19 thank you very much, developers. You had to slog
20 through a long session. We appreciate it.

21 We're going to move on to 3039,
22 preventive care and screening, BMI screening and

1 follow-up.

2 Measure developers here? Is the
3 measure developer on the phone? Oh, they're
4 making their way up. Okay.

5 If you could introduce your measure,
6 two to three minutes, I appreciate it. And then
7 the committee will discuss and if they have
8 questions we'll engage.

9 MS. SOMPLASKY: My name's Anita
10 Somplasky from Quality Insights and with me is
11 KeriAnn Wells from Mathematica Policy Research.

12 On the phone we should have Dr. Dan
13 Green from CMS who will also be answering
14 questions.

15 We are pleased to introduce NQF 0421:
16 Preventive Care and Screening: Body Mass Index
17 Screening and Follow-up Plan for consideration
18 for NQF re-endorsement.

19 We will discuss two versions of the
20 measure - NQF 2828 is the electronic clinical
21 quality measure, and NQF 3039 is the claims and
22 registry version of this measure.

1 This measure was first implemented in
2 a CMS quality program to promote healthy weight
3 by screening patients for BMI scores and
4 identifying patients appropriate for an
5 intervention. That is, those outside of normal
6 parameters.

7 The measure was first implemented in
8 the Physician Quality Reporting System (PQRS) in
9 2008 and it was added to the Electronic Health
10 Record Incentive Program, commonly referred to as
11 Meaningful Use in 2010.

12 The intent of this process measure is
13 that all eligible professionals document a
14 patient's BMI during an encounter, or in the six
15 months before the visit.

16 When a patient's BMI is outside of
17 normal parameters the measure requires that
18 eligible professionals document a follow-up plan
19 such as exercise, nutritional counseling, or a
20 referral to a specialist to help the patient
21 achieve a healthy weight.

22 This measure focuses on adults and

1 includes all visits during the 12-month reporting
2 period.

3 As stated in the 2013 AHA/ACC/TOS
4 Guideline for the Management of Overweight and
5 Obesity in Adults the biomedical, psychosocial
6 and economic consequences of obesity have
7 substantial implications for the health and well-
8 being of the United States population.

9 More than one-third at 34.9 percent of
10 adults in the United States are obese. Obesity
11 among adults younger than 65 has been shown to
12 reduce life expectancy and increase medical
13 costs.

14 Weight loss has been shown to decrease
15 blood pressure, reduce triglycerides and decrease
16 blood glucose levels and hemoglobin A1c, all of
17 which may slow the progression of type 2 diabetes
18 and cardiovascular disease.

19 Unfortunately fewer than 50 percent of
20 obese adults in 2010 received advice to exercise
21 or perform physical activity.

22 On the other end of the spectrum the

1 2007 to 2010 National Health and Nutrition
2 Examination Survey indicated that an estimated
3 1.7 percent of adults in the U.S. ages 20 and
4 older are considered underweight.

5 Elderly patients with unintentional
6 weight loss are at higher risk for infection,
7 depression and death, but these concerns can be
8 alleviated through counseling and monitoring.

9 This measure reflects an important
10 aspect of care that clinicians do not regularly
11 provide.

12 The average 2014 PQRS performance rate
13 was 61 percent with fewer than 20 percent of
14 eligible professionals reporting.

15 This measure has the potential to
16 alert eligible professionals to the importance of
17 identifying populations at risk and treating
18 patients using evidence-based guidelines,
19 maximizing population health and reducing
20 healthcare costs.

21 We thank you for your consideration
22 and look forward to your questions and

1 discussion.

2 DR. NISHIMI: Before we go to the
3 committee's discussion I did have a question for
4 the developer.

5 This was previously endorsed as 0043
6 and it's been resubmitted now and is 3039.

7 Did the specifications change and
8 that's why you resubmitted it instead of
9 referring to it as a straight maintenance
10 measure?

11 MS. SOMPLASKY: We were instructed now
12 that it is an eCQM that we needed to have two new
13 numbers issued which they were and we submitted
14 it that way.

15 DR. NISHIMI: Okay, so then the
16 evidence and testing data and all the other sort
17 of if you will old maintenance still apply to
18 this.

19 MS. SOMPLASKY: Yes, ma'am.

20 DR. NISHIMI: Okay, thank you.

21 MEMBER SPANGLER: Robyn, I have a
22 question about that too. Did you mean 0421? Is

1 that right? Okay, so they're the exact same
2 measure?

3 DR. NISHIMI: When I'm not wearing my
4 glasses I can see neither far nor close
5 apparently.

6 (Laughter)

7 DR. NISHIMI: But yes, thank you,
8 Jason. So this really should be thought of as a
9 maintenance measure.

10 CO-CHAIR QASEEM: Comments? Cathy or
11 Matt or it doesn't matter. Go for it. Cathy.

12 MEMBER HILL: I was just wondering if
13 there is any data especially since this is a
14 maintenance measure around the variations in
15 ethnicity in terms of the ranges of BMI that are
16 considered obese.

17 MS. WELLS: So, we did test the
18 measure in racial categories and we found some
19 differences there. But there was no change to
20 the measure. There was no risk stratification or
21 adjustment on that basis.

22 CO-CHAIR QASEEM: Matt.

1 MEMBER STIEFEL: Just a comment. It's
2 good to see a measure that includes screening,
3 documentation and follow-up unlike many of the
4 previous measures that have been so parsed out
5 that they've been very difficult to evaluate. So
6 this shows that it can be done and I appreciate
7 it.

8 MEMBER SALIVE: So, I was one of the
9 reviewers and I think it's strong. The evidence
10 hasn't changed, but it's still endorsed by the
11 U.S. Preventive Services Task Force.

12 They presented lots of evidence about
13 the gap.

14 It seems quite feasible and I think
15 although some people saw the 19 percent in PQRS
16 as low, I believe it's because they can choose
17 their measures.

18 And so it's actually in the top five
19 of PQRS measures amongst ones reported. So,
20 nothing is much higher than 19 percent.

21 So, hopefully this can get out and be
22 more widespread, but I think they presented a

1 strong case for meeting all the criteria.

2 DR. NISHIMI: Tom.

3 CO-CHAIR McINERNEY: Yes, I'm unclear
4 about a couple of things.

5 Because I don't see adults, I assume
6 most adults, whenever they come into the office
7 for any reason they get weighed. Is that pretty
8 much correct? Is that what internists do? So
9 they get weighed.

10 And you can assume that their height
11 is constant pretty much.

12 CO-CHAIR QASEEM: They check height as
13 well.

14 CO-CHAIR McINERNEY: But probably not
15 as often, right? I mean, I've lost an inch over
16 the years, you know, my intervertebral disc
17 collapse.

18 But so you can -- if you know the
19 height which you say is constant, and you have
20 the weight then the BMI can be easily calculated.

21 Now, that's a little different in
22 pediatrics. We don't do a height and weight at

1 every visit. We only do them at our health
2 maintenance visits.

3 You know, if a kid comes in with an
4 earache we don't do a height and weight so we
5 don't do a BMI.

6 But I guess for adults that's not a
7 big problem because you do it for every visit.

8 The other question I have is you say
9 that there's a plan for follow-up. What do you
10 count as a good plan for follow-up and how do you
11 determine that meets the requirements for the
12 measure?

13 MS. SOMPLASKY: We have not been
14 prescriptive about what follow-up entails because
15 this measure is meant for all eligible providers.

16 So, it's more than just physicians, it
17 includes social workers, psychologists,
18 nutritionists, physical therapists.

19 So, because of that we did not want to
20 be prescriptive and say that it had to include
21 certain testing.

22 So, a referral back to the primary

1 care physician is sufficient. If you are a
2 primary care physician, or one of the specialists
3 seeing them, following -- either recommending a
4 weight management program or reassessment,
5 something in that chart that shows that a follow-
6 up, some sort of follow-up has been documented
7 for BMI outside the parameters.

8 CO-CHAIR McINERNY: You're confusing
9 me a little bit because you're saying social
10 workers, psychologists. Did you say physical
11 therapists?

12 MS. SOMPLASKY: Yes, sir.

13 CO-CHAIR McINERNY: They don't weigh
14 patients on a regular basis.

15 MS. SOMPLASKY: For this measure they
16 do.

17 CO-CHAIR McINERNY: What's that?

18 MS. SOMPLASKY: In order to report
19 this measure which they do they are required to
20 weigh and measure.

21 CO-CHAIR McINERNY: Okay. So the
22 follow-up can be pretty open-ended like you're a

1 little overweight, or you're a lot overweight,
2 whatever you want to say. Eat better, exercise
3 more, come back in six months. I'll weigh you
4 again. And that's considered sufficient.

5 MS. SOMPLASKY: Yes, sir.

6 CO-CHAIR McINERNEY: Well, we know that
7 doesn't work.

8 (Laughter)

9 CO-CHAIR McINERNEY: I mean, come on,
10 let's be honest about it. They come back in six
11 months and you're lucky if they're the same
12 weight. Often they're another pound or two
13 heavier.

14 So, I'm a little concerned that that
15 -- we need to make a better plan to help patients
16 who are overweight. And just come back in six
17 months I don't think really cuts it. I'm sorry.

18 DR. GREEN: Excuse me, can I jump in
19 there for a minute? This is Dan Green from CMS.

20 So, I would agree with you. Ideally
21 we would prefer to have a more robust plan for
22 folks to follow.

1 But I think part of the intent of the
2 measure is to get physicians and other caregivers
3 engaged in confronting patients that are either
4 dramatically over- or underweight.

5 So, just the fact that someone
6 addresses it rather than they put them on the
7 scale and they make no mention of it is better
8 even if the patient doesn't do exactly what's
9 recommended than ignoring it altogether.

10 So, I agree that it could be more
11 robust, but I would also suggest that something
12 is better than nothing.

13 MEMBER HILL: Thank you. So, just a
14 follow-up to my question on diversity because I
15 am aware of data that is out there, especially on
16 the Asian population that we can't measure them
17 the same way and identify obesity the same way as
18 we have done in the past.

19 You mentioned that you did find some
20 differences and that they were not included.

21 Do you have some plan to update your
22 evidence on this measure so that our growing

1 Asian population has an accurate measure of
2 whether they're obese or not?

3 MS. SOMPLASKY: We didn't find
4 statistical differences. We did -- for what it
5 was we did have around ethnicity.

6 And we are aware of the differences
7 for the Asian population that for them they're
8 going to have a much lower threshold than other
9 ethnicities will.

10 But we weren't seeing any statistical
11 difference in what we got in our results.

12 MEMBER CARRILLO: In our ACO we have
13 a lot of experience with this measure. It's one
14 of the required ACO measures.

15 And it's effective. I can say that
16 particularly the follow-up piece. Because the
17 BMI is pretty much baked in and it's part of many
18 usual processes in doctor's offices.

19 And the height you catch once and
20 assume that that more or less stays.

21 But the follow-up which in our case is
22 prescribed as return visit, as counseling, as a

1 weight management program and a couple of other
2 options is part of a dropdown.

3 So, physicians have to actually
4 address in that dropdown what the follow-up is.
5 So we find that we lose points in the follow-up
6 piece.

7 So in terms of our education with
8 doctors we're basically focusing them on you
9 don't just do a BMI, you do something about it.

10 So, we have found that to be a
11 challenging measure, but also a very effective
12 measure for the same reason.

13 MEMBER MOLINE: I'm fixated on the
14 social worker thing. I just, I mean I reviewed
15 these measures and I didn't see anything that
16 would make me remotely think that a psychologist
17 or a social worker was being held to this
18 measure.

19 And I've reviewed a ton of medical
20 records in my career and can never remember
21 seeing a social worker or a psychologist be
22 expected or do these measures unless perhaps they

1 were a bariatric social worker or psychologist.

2 But I don't have experience with that.

3 So can you just clarify very quickly?

4 MS. SOMPLASKY: Sure. In the PQRS
5 reporting program eligible providers in order to
6 not receive a payment adjustment you have to
7 report a set number of measures.

8 This measure when it was originally
9 developed back in 2007 was developed with keeping
10 all eligible professionals that report for the
11 PQRS reporting program in mind. And that does
12 include social workers, psychologists, physical
13 therapists, occupational therapists.

14 They are actually part of our expert
15 work group that we have for this measure so that
16 we were not setting the bar too high for them.

17 But because we have to keep in mind
18 all of those -- they call them the eligible
19 professionals, but all of those specialties that
20 are eligible to report for PQRS, they are
21 included for this measure as well.

22 MEMBER BIALEK: The measure applies to

1 all providers. And whether they're privately --
2 whether the individual patient is privately
3 insured, uninsured, et cetera.

4 So, the data that you have about
5 reporting comes from a selective group. I didn't
6 see anything about the ability for this standard
7 to actually -- for this measure to actually be
8 reported by others who aren't part of either the
9 Medicare system or CMS type of system.

10 MS. SOMPLASKY: So, the Medicaid
11 Meaningful Use program would include this measure
12 as well. That's reported to the states so we did
13 not have that data because that's reported to
14 each state individually and they handle the
15 Medicaid reporting program.

16 It is not -- there are BMI measures
17 that are used in HEDIS and are used by other
18 health plans, but they don't have the same
19 measure we do with that follow-up plan, or the
20 follow-up requirement included with theirs.

21 MEMBER BIALEK: But you're proposing
22 this measure would apply though to everybody, not

1 just Medicare and Medicaid. Correct?

2 MS. SOMPLASKY: When I say all
3 eligible providers for that PQRS reporting
4 system.

5 MEMBER BIALEK: Okay. So the way I
6 read the measure it doesn't specify that this is
7 limited just to -- so is it just limited to the
8 populations you mentioned, Medicare, Medicaid?

9 MS. SOMPLASKY: Anybody could use this
10 measure if they so desired. We just haven't seen
11 anybody outside of Medicare, Medicaid.

12 There's an NQF measure that actually
13 used this as the basis, but they made it very
14 disease-specific.

15 MEMBER VENKATESH: So, Ron, I think
16 actually everybody is included. The measure
17 denominator is all patients age 18 and older.
18 So, everybody's in.

19 It's a pretty basic I think
20 straightforward screening measure. It's hard to
21 measure anything else really in this space.

22 There's a USPTF B-level recommendation

1 that they would meet moderate for evidence. The
2 measure is being used.

3 Nothing really hangs me up about this
4 measure. I think it's a no-brainer we should
5 move forward.

6 I think one of the things just to
7 remember about these measures is that the whole
8 PQRS program that's proof of use of this measure,
9 somebody's score on that is their best case
10 score.

11 And so if there's still evidence
12 according to this that there's still a gap in
13 somebody's best case score.

14 And so chances are the actual scores
15 are even worse. It's a program people can
16 participate in by choice. It's not mandated.

17 But it's important that for those
18 programs individual clinicians have measures
19 available to them, and this is one that hits on a
20 big health topic.

21 And so I kind of would say we should
22 -- it's already endorsed. We should move

1 forward. They're trying to make an EHR version
2 of this measure to make -- reduce the burden of
3 data collection and kind of advance it. It makes
4 sense to me.

5 MEMBER CARRILLO: Well, as was
6 mentioned this is a Meaningful Use tool measure.
7 So it's really anyone -- there's a lot of
8 adoption of Meaningful Use by practices
9 everywhere.

10 And whoever has access to the
11 electronic medical record, be it social workers
12 or physicians, nurses, whatever, will be actually
13 having access and acting on this measure.

14 CO-CHAIR QASEEM: A couple of comments
15 that I want to make after hearing all of what you
16 said.

17 I think we need to be a little bit
18 careful with what the task force recommends
19 versus what the evidence -- what this measure is
20 about.

21 The task force is very specifically
22 screen all adults, but the follow-up plan is in

1 the obese population, not overweight. And there
2 was a lot of discussion in the task force meeting
3 about whether we include the overweight
4 population or not.

5 That's one issue. And the evidence is
6 actually a little bit not clear about it.

7 And the second issue is that you need
8 that multi-component extensive follow-up plan.
9 Going back to what I think Tom was bringing up
10 that's important as well.

11 Just having a follow-up plan has not
12 shown to have any impact on patient population.

13 And the third point I want to raise is
14 the time issue. I was trying to pull the number
15 and my dashboard was crashing on me, the NQF one.
16 But I think it said six months if I remember
17 correctly.

18 And there is -- most of the folks,
19 expert -- there is no evidence. They said once
20 every two years might be a better option to go,
21 or at least once every year.

22 The reason being is that sustained

1 weight loss is important. Just again going back
2 to what Tom brought up, I think it's an
3 incredibly important issue, that every six months
4 you're doing it is not going to really show or do
5 anything in terms of improving health outcome.

6 And again, it's a very important
7 issue. I'm not saying that this is not an
8 important issue.

9 I think everyone in this room is going
10 to agree obesity is an important issue and we
11 don't just figure it out.

12 And some of this conversation, going
13 back to 2014. I honestly don't remember which
14 NQF committee I was on, but this happened at that
15 point as well and CMS was asked to address some
16 of these concerns.

17 And what we were told was next time
18 around when the measure comes for endorsement
19 purposes some of them will be taken into account,
20 including issues such as BMI alone does not help.

21 A lot of new evidence that's out there
22 in terms of waist circumference and waist-to-hip

1 ratio that has shown more direct correlation than
2 just BMI itself.

3 And at that point in time the
4 conversation was that if CMS is going to bring it
5 back for discussion and when next time around the
6 measure will be updated we're going to take that
7 into account.

8 But I haven't seen any change in this
9 measure. It's exactly what it was we discussed
10 last time around.

11 So, can you address some of these?

12 MS. SOMPLASKY: In terms of changing
13 for the follow-up plan we have not made any
14 significant changes to that.

15 And one of the things that we'll talk
16 about is that documentation in the EHR has proven
17 to be very difficult to have that in a structured
18 field and to be able to show that.

19 So, we know that there are challenges
20 with that.

21 We did make recommendations for 2017
22 to have one population and not have the

1 stratification.

2 But because we were testing on 2014
3 data that we had our guidance from NQF was to use
4 the measure that was consistent with the data
5 that we have.

6 But we have not made significant
7 changes to the measure.

8 CO-CHAIR QASEEM: What I'm saying
9 essentially is it's not even consistent with the
10 task force recommendation right now anymore.

11 The task force revised its
12 recommendation and it does not include everyone
13 like the way you have it in this measure. It
14 doesn't match up with that.

15 I can read the task force
16 recommendation right now if you guys want.

17 It says the task force recommends
18 screening all adults, but the clinician should
19 offer to refer patients with BMI greater than 30
20 or higher for intensive multi-component
21 behavioral intervention.

22 If you start going into the clinical

1 consideration and implementation of it, it talks
2 about exactly the issues that have been brought
3 up by this committee at this point.

4 And this recommendation actually came
5 out -- it's been awhile. So, it could have been
6 incorporated by now.

7 MEMBER SALIVE: Any screening
8 recommendation like that is a moving target in
9 some ways. And how you translate it into a
10 quality measure can be argued.

11 That's what I was trying to say this
12 morning. And I think this is what brought it to
13 me because I think there is some wiggle room here
14 on this measure.

15 So, they are also addressing -- the
16 underweight is addressed in this measure and the
17 obese both.

18 But also there's an interpretation
19 role of the physician. There are people, the
20 muscular people who have a high BMI who don't
21 need anything.

22 And you have to sift through that

1 also, and that's still a plan. The plan is do
2 nothing, actually. They're muscular.

3 And the timing, I mean I think the
4 USPSTF recommendations always have these subtle
5 gradations that don't translate well into quality
6 measures.

7 So, you know, I think it's a trade-off
8 between -- they've tweaked the measure basically
9 into two forms, the registry and claims one that
10 we're talking about now, and the eMeasure.

11 I think it's somewhat popular from the
12 evidence. Is it perfect? I doubt it's perfect,
13 but I doubt we'll ever have a perfect one.

14 CO-CHAIR QASEEM: And I don't know if
15 we'll be able to debate that today or not.
16 That's a very interesting perspective, Marcel.

17 I agree with you. I'm not disagreeing
18 with you. But what I'm saying is just because
19 something is good clinical care do we have to
20 have a performance measure for it? Does every
21 single thing we do in our clinical practice needs
22 to translate into a clinical performance measure?

1 That's one thing.

2 And I think I would have been more
3 willing to go take that route until performance
4 measures became a high-stakes game under MACRA by
5 CMS.

6 If you're going to be measuring
7 physicians and now you're going to be impacting
8 their -- essentially it's pay-for-performance now
9 then you need to come up with performance
10 measures that are at least based on evidence, if
11 you're going to go with evidence.

12 And we need to apply the evidence
13 uniformly. What I heard today was some of the
14 measures that we were approving we were saying
15 oh, it's a task force recommendation. Let's go
16 for it.

17 And then if that's what the standard
18 is then let's stick with that standard. If
19 that's not what the standard is let's apply --
20 let's not pick and choose standards based on
21 which measure we are reviewing, or where is it
22 coming from.

1 I want consistency across the
2 measures, but that's what I'm struggling with.

3 There are many good performance
4 measures that are out there that are good
5 evidence base.

6 And remember that the guideline in
7 performance measures -- it's all of your
8 clinicians.

9 The guidelines, I can apply the
10 guideline and make a judgment call. On
11 performance measures it's not the case.
12 Performance measure is saying you need to do this
13 in every patient.

14 There's a huge difference between
15 guideline and performance measure. And I think
16 guidelines give you some flexibility.
17 Performance measures don't.

18 And I'm not saying I'm disagreeing.
19 Obesity is a huge issue. It's an important topic
20 area, I'm not going to disagree.

21 Absolutely it's a good clinical
22 practice as well. I'm not going to disagree with

1 that.

2 What I'm saying is that at least it
3 should show what the current evidence is showing,
4 and what -- and what the governmental agency is
5 saying. Either we agree with task force or we
6 don't agree with task force.

7 DR. GREEN: This is Dan Green again.
8 I think you need to be a little bit -- have some
9 blinders on in terms of the program and the
10 higher stakes of quality measures.

11 To your point I don't think anybody
12 can argue with the importance of assessing one
13 state, particularly given the epidemic of obesity
14 in our country.

15 Now again, I know the measure talks
16 about underweight individuals as well, but let's
17 focus on the overweight for just a minute.

18 The measure certainly may have room
19 for improvement, but I believe there's a measure
20 that's been NQF-endorsed that just assesses BMI.

21 So you know, that's like asking a
22 cigarette smoker if they smoke and documenting

1 it. Well, that's great, but if you're never
2 going to counsel them, or even make any effort to
3 try to get them to get their smoking under
4 control, or in this case their weight under
5 control you've not really done anything.

6 It doesn't take a task force and it
7 doesn't take a rocket scientist to figure out if
8 somebody's overweight they should be at least
9 advised and have some effort made to have them
10 get their weight under control.

11 So, I'd hate to throw the baby out
12 with the bath water so to speak as it relates to
13 this measure.

14 It's an optional measurement -- you
15 mentioned our programs. It's an optional measure
16 for folks to report in our PQRS program and it's
17 proposed to be optional under the new MACRA
18 legislation.

19 So not making anybody do this measure.
20 But I think it's an important measure that we
21 continue.

22 CO-CHAIR QASEEM: And I absolutely

1 agree it's an important measure. I'm not arguing
2 that.

3 I'm just pointing out there are a lot
4 of things that could have been updated with this
5 measure including as I said the follow-up plan
6 alone. There is enough evidence out there that
7 shows just follow-up plan does not change.

8 So if CMS really wanted to improve the
9 patient outcomes we need to really work on what
10 is going to change. Just follow-up plan has
11 never shown.

12 And even in terms of the intensive
13 therapies that you're talking about it takes 12
14 to 18 months to show any change.

15 And I'm not even talking about
16 statistical change. And I can send you a lot of
17 good evidence on this one if you look at the
18 literature on this.

19 So, all I'm saying is this measure is
20 saying six months, you need to do something every
21 six months.

22 You're not talking about -- you just

1 have it as follow-up plan. It does not get into
2 intensive -- or give some guidance which is going
3 to make a difference.

4 Obesity is an important issue and
5 let's do it the right way. Just having it as a
6 checkbox as a measure that yes, we have a measure
7 on obesity is not going to change the attention
8 out there, at least in my opinion.

9 DR. GREEN: I agree a more robust plan
10 would be beneficial, but we don't want to sit
11 there and tell physicians and other eligible
12 professionals how they should be providing care.

13 It's a guideline. Are you asking your
14 patients and assessing your patients' weight.

15 And if you are and they fall out of
16 the norms are you at least guiding the patient as
17 to where they can get help, or how they can get
18 help.

19 CO-CHAIR QASEEM: This is not a
20 guideline though, I disagree. You have it as a
21 performance measure. You used the term
22 guideline.

1 If it's a guideline I'm perfectly fine
2 with it.

3 DR. GREEN: I said are you guiding.
4 I didn't say guideline. I said if you fall out -
5 - yes, I did. I said if you fall out of the BMI
6 norms are you sending the patient for -- giving
7 them guidance to get help to try to get their
8 weight under control.

9 CO-CHAIR QASEEM: All right. So, the
10 last two comments and then we'll vote. Marcel
11 and Emilio.

12 MEMBER CARRILLO: Just to say that
13 perfection is the enemy of the good.

14 And if we don't have providers,
15 physicians paying attention to people being out
16 of range, up or down, the best laid plan for
17 improvement is not going to do anything.

18 So, to get docs focused on the BMI
19 which you would think they would. Our experience
20 in our ACO is that they don't.

21 So I just think that it's a good first
22 step.

1 DR. NISHIMI: Ready?

2 CO-CHAIR QASEEM: What are we voting
3 on?

4 DR. NISHIMI: Evidence.

5 MS. CRAWFORD: Voting is open for
6 measure 3039 on evidence. One - high, two -
7 moderate, three - low, four - insufficient.

8 We have 2 high, 10 moderate, 3 low, 1
9 insufficient. Thirteen percent high, 63 percent
10 moderate, 19 percent low, 6 percent insufficient.

11 DR. NISHIMI: Okay, the next issue is
12 performance gap. We kind of did this discussion
13 already so let's vote on gap.

14 MS. CRAWFORD: One - high, two -
15 moderate, three - low, four - insufficient.

16 We have eight high, eight moderate.
17 Fifty percent high, 50 percent moderate.

18 DR. NISHIMI: Okay. It passes gap.
19 We can go onto scientific acceptability.

20 They did empirical testing for
21 reliability at the score level so it is eligible
22 for high.

1 It was a signal-to-noise ratio.
2 That's typical of reliability testing. And the
3 reliability statistic was 0.75. So that's
4 generally considered good.

5 MS. CRAWFORD: Voting is open for
6 measure 3039 reliability. One - high, two -
7 moderate, three - low, four - insufficient.

8 We have 10 high, 6 moderate, zero low,
9 zero insufficient. Sixty-three percent high, 38
10 percent moderate.

11 DR. NISHIMI: So it passes the
12 reliability criterion.

13 For the validity testing it is data
14 element level, manual abstraction against an EHR
15 extract. So, as data element validity testing it
16 is eligible for a moderate rating.

17 The agreement on the numerator was
18 90.16 percent. The kappa was 0.8. And for the
19 denominator it was 99 percent and the kappa was
20 low, 0.4, but the developer attributes that to
21 the low number of exclusions in the extracted
22 data.

1 So, if the committee has any
2 discussion on that. Ready to vote?

3 MS. CRAWFORD: Voting is open, measure
4 3039 on validity. One - moderate, two - low,
5 three - insufficient.

6 We have 12 moderate, 4 low, zero
7 insufficient. Seventy-five percent moderate, 25
8 percent low.

9 DR. NISHIMI: Okay, so the measure
10 passes validity.

11 Onto feasibility. We've already
12 discussed the feasibility to some extent. Are
13 there any additional comments?

14 Okay, let's vote on feasibility.

15 MS. CRAWFORD: Vote on measure 3039 on
16 feasibility. One - high, two - moderate, three -
17 low, four - insufficient.

18 We have 4 high, 11 moderate, 1 low,
19 zero insufficient. Twenty-five percent high, 69
20 percent moderate, 6 percent low, zero percent
21 insufficient.

22 DR. NISHIMI: Okay, overall

1 suitability for endorsement. Oh, I'm sorry,
2 usability and use.

3 MS. CRAWFORD: Voting is open for
4 measure 3039 usability and use. One - high, two
5 - moderate, three - low, four - insufficient
6 information.

7 We have seven high, eight moderate,
8 one low, zero insufficient. Forty-four percent
9 high, 50 percent moderate, 6 percent low, zero
10 percent insufficient information.

11 DR. NISHIMI: Okay. Now, overall
12 suitability for endorsement.

13 MS. CRAWFORD: Voting is open for
14 measure 3039 overall suitability for endorsement.
15 One - yes, two - no.

16 We have 15 yes, 1 no. Ninety-four
17 percent yes, 6 percent no.

18 DR. NISHIMI: So for measure 3039 the
19 committee recommends the measure.

20 The next measure I just want to say --

21 CO-CHAIR McINERNEY: Before we leave
22 that could we maybe ask -- just have the

1 committee get a sense that we would ask the CMS
2 folks to come back in the near future with a more
3 robust plan, or a choice of more robust plans
4 other than just follow-up in six months.

5 I kind of like the idea Emilio said,
6 a dropdown list. And I think in this day and age
7 of EHRs there may be something that you could do
8 with the dropdown list and hopefully you actually
9 do what you say you did in the dropdown list.
10 That's always a question.

11 And we know that I think there are --
12 we need to find some evidence-based measures that
13 work, that have been shown to really work to
14 improve the outcome.

15 I think we're seeing some evidence
16 that motivational interviewing has a much better
17 outcome than just saying come back in six months.

18 I don't know about referrals to
19 dietitians, et cetera, or referrals to gyms or
20 whatever else. I'm not sure there's much
21 evidence for those.

22 But I think we need to move this up,

1 to raise the bar, to move this up to another
2 level. We need to look at some evidence-based
3 results that really help patients to improve
4 their BMIs.

5 And by soon I mean a year or 2, not 5
6 or 10.

7 MEMBER TEUTSCH: I would also support
8 Amir's contention that we really need to get this
9 better aligned with the Preventive Service Task
10 Force recommendation along the dimensions that he
11 talked about, particularly about who it is that
12 needs to get referred.

13 I would also point out to Tom's
14 comment that there's been a lot of work on
15 community-based interventions and resources.

16 This is not the sole providence of
17 clinical care or public health alone. This is a
18 real opportunity to get people connected to the
19 resources they need regardless of whether they're
20 inside or outside the clinical care system.

21 DR. NISHIMI: So we'll make sure the
22 report reflects these.

1 CO-CHAIR McINERNEY: Well, you can look
2 at the community guide for one simple place, or
3 the IOM reports on obesity control. There are a
4 bunch of resources.

5 And I don't think we want to be
6 categorical, but clinicians should be aware of
7 what they are and take advantage of the ones that
8 are available to them.

9 MEMBER STIEFEL: And especially since
10 this also includes underweight.

11 MEMBER TEUTSCH: It's interesting, the
12 Task Force doesn't talk about the underweight
13 problem. Their recommendation is for referral of
14 the obese.

15 That's not to say that you shouldn't,
16 but it's the same issue. There isn't a specific
17 recommendation to that effect.

18 DR. NISHIMI: So, I think the
19 developer clearly heard the comments on how this
20 measure can be improved and we'll make sure the
21 report also reflects that.

22 Okay, the next measure is 2828. This

1 is the eMeasure version of this. So we'll carry
2 over the evidence discussion to this measure.
3 There's no need to revisit that.

4 The question is based on the
5 information that they supplied, is there a gap.
6 So we do need to vote on that quickly.

7 And then it's whether or not the
8 testing information that they supplied, using it
9 as an eMeasure is valid and reliable, et cetera.
10 And then obviously the feasibility.

11 DR. GREEN: This is Dan Green. I'm
12 going to drop off, but I just wanted to thank the
13 committee. Thank you.

14 DR. NISHIMI: Thank you. We aren't
15 going to discuss evidence. We're going to go
16 straight to gap.

17 Is there anything new that anyone
18 wants to add about gap? Does anyone object if we
19 vote? Ron.

20 MEMBER BIALEK: And this is really a
21 question for the developers in terms of gap.

22 When I was looking at the data it

1 seemed like you indicated that the data, it's not
2 part of the structured field for the electronic
3 reporting, and that also one of the three
4 providers that you do testing with, 11 percent
5 didn't record the BMI data.

6 And so I'm just -- I'm not sure, maybe
7 I'm misinterpreting the data, but it seems to me
8 that if it's not part of the electronic reporting
9 how do we determine the gap.

10 MS. WELLS: So we tested the measure
11 at three sites and only one of them had a
12 dropdown menu that listed care plans such as
13 consultation for diet, diet and exercise. And so
14 the feasibility was very much improved obviously
15 at that site compared to the other two.

16 So it speaks to the variation in
17 feasibility I think across settings, but it is
18 just one enhancement to the EHR. It does sort of
19 structure that follow-up data which otherwise was
20 in notes in care plans and sort of non-query-able
21 fields.

22 In terms of the 11 percent that failed

1 at our one practice that did have the dropdown, I
2 actually think what happened there was that
3 either they didn't measure the BMI or they did
4 and didn't provide follow-up for one reason or
5 another.

6 It may have been because it was in the
7 25 to 30 range and they decided it wasn't
8 necessary. So they didn't get 100 percent
9 performance, but they did perform quite high.

10 CO-CHAIR McINERNEY: In pediatrics
11 almost all -- after a lot of beating of the
12 electronic health record developers we got them
13 to put in a system, a program that when the
14 height and weight and gender are entered it
15 automatically calculates the BMI and reports it.
16 So that makes life a lot easier.

17 I've been around long enough to
18 remember going around with some -- trying to do
19 the calculations. It drove me nuts. I don't
20 know why they came up with such an arcane
21 formula.

22 But anyway, in adults I don't know if

1 that automatically happens.

2 MS. SOMPLASKY: It does not.

3 CO-CHAIR McINERNY: And that's
4 certainly something that should be done is that,
5 you know, they should know the gender. The
6 height they can assume is staying the same. So
7 that if you weigh them it should automatically
8 give you the BMI. That's the first part.

9 Then the second part is I guess for an
10 electronic measure the clinician, whoever it is,
11 has to check off that they -- at this point the
12 low bar is that they advise the patient about
13 their being overweight and come back in six
14 months.

15 But hopefully we'll get dropdown menus
16 that will be --

17 MS. SOMPLASKY: And that is the
18 variability among EHR vendors. Vendors
19 interpreted this measure so some do have
20 dropdown.

21 And one of the things we tried to do
22 when we tested, we tested in a very small

1 practice, a medium-sized and a large practice
2 with three different vendors.

3 Two of the three vendors were going to
4 charge that practice to make changes. And the
5 minute you start passing on changes like that the
6 practices can't afford it.

7 So, they find -- we did find
8 documentation in non-structured fields, but you
9 can't pull that information to be able to provide
10 it just from the EHR extraction.

11 MEMBER HARRIS: So I just wanted to --
12 the developer took part of the things I wanted to
13 say is that there are certain EHRs that do have
14 the capacity to automatically calculate.

15 And I think that if it's not
16 automatically there then it's not a really good
17 EHR system.

18 Secondly, I think that as a clinician
19 and paying attention to that particular feature
20 is going to require a little bit more than just
21 it calculating in the background, where it will
22 actually be prompted.

1 So like in the EHR system that I've
2 recently used it actually turns the field red
3 when you look at the actual calculations based
4 upon what the card we used to carry in the lab
5 coat. And we pulled it out and looked at the
6 orange-yellow, green-yellow, whatever.

7 So, I'm not sure if that's in this
8 methodology or not but that's something that is
9 available.

10 CO-CHAIR McINERNEY: I think as an
11 aside we need to have the government harass EMR
12 vendors at least as much as they harass
13 clinicians.

14 MEMBER HARRIS: I concur.

15 DR. NISHIMI: Okay, are we ready to
16 vote on performance gap, or any other questions?
17 Oh, I'm sorry.

18 MEMBER MOLINE: First of all, I'd like
19 to say that this measure made me feel comfortable
20 that in a few years when I hit 65 I don't have to
21 worry about a BMI of 25 anymore. I can go up to
22 30 and be considered normal so that should be

1 nice for everybody. Because I didn't know that.
2 So you learn something from being on this
3 committees.

4 But to your point, a lot of the EMRs
5 do automatically calculate the BMI. And it's
6 unusual that they don't.

7 At this point if the height and weight
8 are inputted it becomes something standard. When
9 they're inputted it becomes -- because I can tell
10 you my staff wouldn't figure out how to do it and
11 it's done automatically.

12 So at least in Allscripts it gets
13 done.

14 So is there -- I think there's some
15 other issues that we'll probably get to with
16 usability which goes to the dropdown fields, but
17 also goes to some of the exclusions that there
18 was no way of getting to that we're going to get
19 to where there's no availability in the
20 electronic medical record to say urgent care or
21 not, which is an exclusion. So, I think those
22 are some more of the challenges with this

1 measure.

2 MS. SOMPLASKY: To be clear, you are
3 correct, the BMI gets calculated. It's when it
4 is out of normal parameters that there are a fair
5 number of EHRs out there that do not have that
6 information in dropdown fields so that it can be
7 part of structured fields.

8 MEMBER HARRIS: Are we talking about
9 a cookbook plan? So like if I'm 30 then you're
10 going to do one thing, and if I'm 35 I'm going to
11 refer you to bariatric surgery, or for 27 I'm
12 going to just tell you to go walk to the White
13 House and back? What exactly are we saying?

14 MS. SOMPLASKY: Well, that's where I
15 said before we're not prescriptive on what that
16 follow-up plan is.

17 And that is one of the things that
18 we're trying to look at with some of those value
19 sets.

20 And we've received a fair number of
21 comments back from EHR vendors saying we need
22 more specificity around this. So we are looking

1 at that for the 2018 specifications.

2 DR. NISHIMI: Any other comments on
3 gap? Vote.

4 MS. CRAWFORD: All right. Voting is
5 open for measure 2828 on performance gap. One -
6 high, two - moderate, three - low, four -
7 insufficient.

8 We have seven high, seven moderate,
9 one low. Forty-seven percent high, 47 percent
10 moderate, 7 percent low, zero percent
11 insufficient.

12 DR. NISHIMI: Okay, so it passes gap
13 and we'll move onto testing.

14 Again, this was an eMeasure. Any
15 comments from the reviewers on testing?

16 MEMBER MOLINE: So this is where some
17 of these are challenging. And the EMR people,
18 the practices and the data that were submitted
19 noted some of the challenges, that there's no way
20 of noting whether someone's in palliative care.

21 More importantly if they were for an
22 urgent or emergent visit in which case they're

1 not in there. And so the EMR did not allow them
2 to distinguish that.

3 Some EMRs -- I mean, I'm trying to
4 think of my various choices. It's not going to
5 give those choices.

6 So as an eMeasure with these
7 exclusions I don't know how that's going to be
8 captured appropriately to change the numerator --
9 or adjust the numerator down without the EMR
10 being modified in some way, and I don't see that
11 happening.

12 DR. NISHIMI: So, you would say that
13 the validity and reliability are affected because
14 of this.

15 MEMBER MOLINE: I think they will be
16 affected by this, yes. I mean, it's not going to
17 be as good as it would have been with these
18 various exclusions as described in the measure.

19 DR. NISHIMI: Marcel or Ron, any other
20 comments? Anyone else, comments? Anyone else
21 have comments? Validity and reliability of the
22 eMeasure version.

1 Jacki has indicated that she has some
2 concerns.

3 Okay, let's vote on reliability. It
4 is eligible for high.

5 MS. CRAWFORD: We have 1 high, 13
6 moderate, 1 low, zero insufficient. Seven
7 percent high, 87 percent moderate, 7 percent low,
8 zero percent insufficient.

9 DR. NISHIMI: Okay, in terms of
10 validity this is more towards where the
11 specifications issue and the availability of the
12 capacity to capture the exclusions.

13 As Jacki pointed out she has some
14 concerns about for the empirical testing for the
15 validity here was done at the data element level.
16 So it will only be eligible for a moderate
17 rating.

18 Any other discussion? Jacki's given
19 her input. Marcel or Ron, did you have any
20 additional comments? No?

21 Okay, then we'll go ahead and vote on
22 validity.

1 MS. CRAWFORD: Voting is open on
2 measure 2828 on validity. One - moderate, two -
3 low, three - insufficient.

4 We have seven moderate, eight low.
5 Forty-seven percent moderate, 53 percent low.

6 So the committee did not reach
7 consensus on the validity criterion. We'll
8 discuss feasibility, and usability and use, but
9 we won't vote on overall endorsement at this
10 time.

11 Feasibility. They did the NQF
12 feasibility score card.

13 It noted that just as Jacki said
14 follow-up is not in a structured field so that
15 identifying those that fall within and outside of
16 the measure could be problematic.

17 Same issue goes to the EMR version's
18 feasibility. Any other questions?

19 CO-CHAIR McINERNEY: Well, since I
20 retired I don't have to deal with some of these
21 issues anymore, particularly ICD-10.

22 When ICD-10 -- are there different

1 codes for the BMI so that if your BMI is within
2 normal range that's one code, or if it's
3 elevated, say a 30 it's another, and if it's 35
4 it's yet another.

5 There are. So that would make it easy
6 to collect that measure. Then I guess the other
7 question, and this may be more with CPT codes, if
8 you recommend something is there a CPT code for a
9 referral to another source or anything like that.

10 MS. SOMPLASKY: We actually created
11 that on the claims registry side, to be able to
12 have a HCPCS code to show it which is why you saw
13 better performance there.

14 It's not there, and that is one of the
15 things I was saying earlier that we are trying to
16 look at, trying to put together value sets that
17 would reflect that referral to another provider
18 for a specific reason, not just in general.

19 To be able to get more specific for
20 this measure. And that is something that we're
21 working on now for 2018.

22 CO-CHAIR McINERNY: Thank you.

1 DR. NISHIMI: Okay, let's go ahead and
2 vote on feasibility.

3 MS. CRAWFORD: Voting is open for
4 measure 2828 on feasibility. One - high, two -
5 moderate, three - low, four - insufficient.

6 MEMBER HARRIS: Tom, while the votes
7 are being cast that particular ICD-10 is easy
8 because it's really the number, whatever your BMI
9 is. So it's a Z code and it's Z68. And then if
10 you're 30 it's Z68.30. If you're 27 it's dot 27.

11 So it's not easy to remember all the
12 ICD-10s period, but like we couldn't remember the
13 ICD-9s, but this is one you could remember.

14 DR. NISHIMI: We're still looking for
15 one more vote. Point your clickers again and hit
16 them again, please. We're still waiting for one
17 more.

18 MS. CRAWFORD: Okay, we have six high,
19 six moderate, three low, zero insufficient.
20 Forty percent high, 40 percent moderate, 20
21 percent low, zero percent insufficient.

22 DR. NISHIMI: Feasibility isn't a

1 must-pass criterion so we'll now vote on
2 usability and use.

3 Any comments from the committee on
4 usability and use? Let's go ahead and vote then.

5 MS. CRAWFORD: Voting is open for
6 measure 2828 on usability and use. One - high,
7 two - moderate, three - low, four - insufficient
8 information.

9 Two more votes please. We have four
10 high, nine moderate, two for low, zero
11 insufficient information.

12 Twenty-seven percent high, 60 percent
13 moderate, 13 percent low, zero percent
14 insufficient information.

15 DR. NISHIMI: Okay, there was a
16 concern by a committee member that they mishit on
17 the validity vote which was consensus not
18 reached. So we're going to go back and redo the
19 validity vote. They're afraid they didn't hit
20 the correct button.

21 So this is validity for the eMeasure.
22 The high comes off.

1 MS. CRAWFORD: So one is moderate, two
2 is low, three is insufficient. Voting is open
3 again for validity of measure 2828. One -
4 moderate, two - low, three - insufficient.

5 Okay, we have 10 moderate, 5 low, 67
6 percent moderate, 33 percent low, zero percent
7 insufficient.

8 DR. NISHIMI: A lot of people must
9 have thought they -- okay, so then all the must-
10 passes have been cleared, so now let's vote on
11 final.

12 MS. CRAWFORD: Voting is open for
13 overall suitability for endorsement on measure
14 2828. One - yes, two - no.

15 Okay, we have 14 yes, 1 no. Ninety-
16 three percent yes, 7 percent no.

17 DR. NISHIMI: Okay. We have one more
18 measure to do, 3062, Hypertension Screening for
19 Children who are Overweight or Obese. Are the
20 developers here? Are the developers on the
21 phone?

22 So while we're waiting for the

1 developers we'll ask them to introduce their
2 measure briefly.

3 This is a new measure. It's a plain
4 old measure. It's not an eMeasure. So we'll
5 just discuss as we do evidence, performance gap,
6 testing, et cetera.

7 MEMBER MOLINE: This shouldn't skew.
8 I just wanted to say that this was the first time
9 in any measure that I've seen socioeconomic
10 status in a measure in any of the ones that I've
11 looked at.

12 And last time we were all together she
13 was sitting over there, I forget who it was, but
14 every single measure she said she wanted to see
15 socioeconomic status.

16 So I feel like she's here in spirit.
17 I forget what her name was. It was Renee. So,
18 someone heard her.

19 MS. MUNTHALI: Is Q-METRIC or
20 University of Michigan with us on the phone?

21 Okay, so let me just see who from
22 there. Operator?

1 OPERATOR: Yes, ma'am.

2 MS. MUNTHALI: Is Gary Freed, Joyce
3 Lee, Julie McCormick, or Caroline Shevrin on the
4 phone from Q-METRIC or the University of
5 Michigan?

6 OPERATOR: I don't see either one of
7 those on the line yet.

8 MS. MUNTHALI: Interesting. Okay, so
9 we're going to try and email them really quickly
10 and see.

11 So while we do that we're going to try
12 and get you out early. And we will forego our
13 discussion on harmonization of the influenza
14 measures.

15 We want to make sure that we have as
16 much of the committee here, and we know you're
17 very tired because you've done a lot of work and
18 so we thank you so much.

19 So we're hoping we can get this
20 measure reviewed as well. If not, this will have
21 to be in the post in-person meeting call which I
22 think is on the 22nd of this month.

1 So, we're going to give the developers
2 one last chance to join us. We're not sure what
3 happened.

4 CO-CHAIR McINERNY: While we're
5 waiting for that could we have one or two of the
6 subcommittee members give their input, like Matt
7 or Jacqueline?

8 Well, yes, I'm also -- yes. Go ahead,
9 Matt.

10 MEMBER STIEFEL: Sure. So, there's
11 going to be I think a pretty significant issue
12 with regard to evidence so this could be a short
13 discussion in that the evidence provided isn't
14 specific to the performance measure because the
15 evidence isn't specific to this testing above the
16 85th percentile for BMI for hypertension.

17 So the staff review concluded it was
18 insufficient and I concur with the staff review.

19 DR. NISHIMI: Jacki, you were also a
20 reviewer. Was that your conclusion on the
21 evidence?

22 Matt's conclusion was that the

1 evidence was insufficient.

2 CO-CHAIR McINERNEY: Yes. And I also
3 agree.

4 DR. NISHIMI: So, the question I guess
5 to Matt and Tom and Jacki is would you recommend
6 it for the exception so that it would be a
7 national performance measure, or should the
8 committee just vote.

9 MEMBER STIEFEL: I think I would not
10 because there's -- I think if you go through the
11 list of the subsequent categories there are also
12 problems with a number of the other elements
13 including the second one in terms of the
14 opportunity for improvement.

15 The opportunity for improvement with
16 one study showed that there was opportunity, but
17 the reliability and other validity measures were
18 -- the information presented was not sufficient
19 in my review.

20 MEMBER MOLINE: I felt it was an
21 immature measure in that it didn't have enough
22 data behind it to be able to show evidence.

1 There's not -- there's some good
2 evidence and there's not. And ironically the New
3 York Times talks about blood pressure screening
4 in kids today so that high-quality journal is
5 talking about the importance. So I thought that
6 was very topical for today.

7 But apart from that they just didn't
8 -- the measure developers didn't present enough
9 information for us to be able to adequately
10 evaluate.

11 And I think they need a couple of more
12 years or more data to be able to come back and
13 present it.

14 I don't think it's a bad thing to
15 present, but I just think there wasn't enough
16 there yet.

17 DR. NISHIMI: Yes, they had a small
18 sample size that once they kept extracting they
19 got down to six records.

20 MEMBER STIEFEL: You're right, the
21 review came down to six records.

22 DR. NISHIMI: Okay. I'm going to do

1 this. We're still trying to get a hold of the
2 developer. We'll allow them to make their pitch
3 if they come on before we're ready to leave.

4 But let's vote on evidence.

5 MS. CRAWFORD: Voting is open on
6 measure 3062 on evidence. One - high, two -
7 moderate, three - low, four - insufficient.

8 Okay, we have zero high, zero
9 moderate, 1 low, 13 insufficient.

10 DR. NISHIMI: So then let's go to the
11 insufficient with exception vote just to close it
12 out.

13 So this is whether the committee wants
14 to consider giving this measure the exception.

15 MS. CRAWFORD: The options are one -
16 insufficient evidence with exception, two - no
17 exception.

18 We have 1 for insufficient evidence
19 with exception, 13 with no exception.

20 DR. NISHIMI: Okay, so the measure is
21 not recommended by the committee.

22 Elisa, do you want to take it? Tom?

1 CO-CHAIR McINERNEY: Let me just --
2 eventually when you report back to the developers
3 my notion is that this is a good idea, we really
4 should be doing this, it's just not quite ready
5 yet for prime time I guess.

6 And they need to work better on the
7 measures and so forth.

8 And one of the things, I don't know
9 if, again because I haven't been in practice in
10 two or three years, whether EMRs are doing a
11 better job of calculating whether the blood
12 pressure is greater than the 95th percentile.

13 For children it's not an easy
14 calculation. You need the gender, you need the
15 height and you need the blood pressure. So
16 that's a three-parameter table.

17 And it covers about -- for males it
18 covers two pages and for females it covers
19 another two pages.

20 So, to do it by hand you get the blood
21 pressure reading and then you've got to go
22 through this.

1 Now, I've talked to some people who
2 say that the EMR should be able to calculate that
3 just the way they can calculate a BMI. The
4 parameters are there, the height's there, the
5 gender's there, the blood pressure is there so
6 the EMR should be able to say whether it's above
7 the 95th percentile or not.

8 But I'm not sure that happens in many,
9 if any EMRs and I think that's part of the thing
10 we should ask the developers to let us know about
11 whether EMRs are beginning to do this in a more
12 regular fashion.

13 It's a lot more difficult than adults
14 because of the height is an important factor.

15 Plus the age. I should say age is
16 another factor. So it's height, age, gender,
17 blood pressure. Those four parameters have got
18 to be all taken into account.

19 DR. NISHIMI: Thanks, Tom.

20 CO-CHAIR McINERNY: Thank you.

21 DR. NISHIMI: Elisa?

22 MS. MUNTHALI: So, we've completed a

1 review of 24 measures over 2 days. That's quite
2 a bit. A number of eMeasures, composites,
3 intermediate outcome measure, an outcome measure,
4 a number of influenza measures.

5 And we were due to talk about
6 harmonization of those influenza measures. And
7 we'll do that later.

8 But we really wanted to thank you so
9 much for getting through all of the agenda items.

10 You've probably worked enough. We
11 will not I think -- we're not going to have the
12 post-meeting call. So we're going to give you
13 back time. We'll cancel it on your calendars.

14 But before I turn it over to public
15 comment I just wanted to thank each and every one
16 of you. We know that the turnaround time was
17 very short, the volume of material you received
18 was a lot and we just wanted to thank you so much
19 for your thoughtful review.

20 We thought it was such a successful
21 meeting. We want to thank the developers and
22 also our co-chairs Tom and Amir today for

1 facilitating such a wonderful meeting.

2 And I'd like to thank my colleagues as
3 well. So with that I'll turn it over to our
4 operator to see if there are any public comments
5 on the phone and then see if anybody who's left,
6 if there are any public comments here.

7 So, Operator, can you open up the
8 lines?

9 OPERATOR: Yes, ma'am. At this time
10 if you would like to make a public comment please
11 press star then the number 1. And there are no
12 public comments at this time.

13 MS. MUNTHALI: Thank you very much.
14 And I'll turn it over to Yetunde for next steps.

15 MS. OGUNGBEMI: Good afternoon. I
16 thank you for a very fruitful and full discussion
17 today and yesterday.

18 I want to review the next steps of the
19 committee and basically the remaining timeline.

20 On well, I should say later this week
21 staff will begin drafting the final report. And
22 this will be complete with committee

1 deliberations.

2 And we will post this draft report for
3 NQF member and public comment from October 20
4 through November 18.

5 Following that commenting period the
6 committee will meet to review and discuss
7 measures where consensus not reached. And that
8 is on December 6.

9 NQF member vote will happen from
10 December 21 to January 4, 2017 on recommendations
11 by the committee.

12 The Consensus Standards Approval
13 Committee, warmly known as CSAC, will meet in
14 either January or February of 2017 to review
15 committee deliberations and recommendations made
16 on a date to be determined. And that should be
17 coming in soon weeks.

18 The committee co-chairs will be asked
19 to join that call and provide CSAC with specific
20 nuance if needed.

21 And recommendations finally will go
22 through appeals from February 3 to March 16.

1 DR. NISHIMI: I just wanted to lend my
2 thanks to everyone. This was a heroic effort.
3 Twenty-four measures is really at the outer
4 limit, and you really marched through them I
5 thought with very thoughtful discussions.

6 As the staff drafts the report we
7 might be in touch with you. You know, we said
8 this. We aren't quite sure what exactly you
9 meant, or we want to make sure we capture the
10 appropriate nuance.

11 But other than that there won't really
12 be any major follow-up till you get the comments
13 and decide on those consensus not reached
14 measures.

15 CO-CHAIR McINERNEY: And on my part and
16 I think for the committee's part we couldn't have
17 done the 24 measures without your help.

18 Your evaluations helped guide us and
19 made I think the process run more smoothly.

20 Now, on this calendar I'm a little
21 confused. What's on September 22? Anything?

22 DR. NISHIMI: That's the thing that

1 we'll send you the cancellation for.

2 CO-CHAIR McINERNY: Okay. And then on
3 December 6, that's still on the calendar?

4 DR. NISHIMI: Yes, you should all have
5 that in your Outlook appointments.

6 CO-CHAIR McINERNY: Okay.

7 DR. NISHIMI: So what happens is we'll
8 get the comments in and we'll let you know what
9 people think.

10 CO-CHAIR McINERNY: Good. Okay.
11 Thank you very much.

12 MS. MUNTHALI: Thank you. Travel
13 safely.

14 DR. NISHIMI: Safe travels to all.

15 (Whereupon, the above-entitled matter
16 went off the record at 2:59 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

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Date: 09-13-16

Place: Washington, DC

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