NATIONAL QUALITY FORUM

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MEASURE APPLICATIONS PARTNERSHIP
CLINICIANS WORKGROUP

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THURSDAY
DECEMBER 10, 2015

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The Work Group met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Bruce Bagley and Eric Whitacre, Co-Chairs, presiding.

PRESENT:

BRUCE BAGLEY, MD, Co-Chair
ERIC WHITACRE, MD, FACS, Co-Chair
TERRY ADIRIM, MD, MPH, FAAP, American Academy of Pediatrics*
BETH AVERBECK, MD, Minnesota Community Measurement
MADY CHALK, PhD, MSW, Treatment Research Institute
LUTHER T. CLARK, MD, Individual Subject Matter Expert
CONSTANCE DAHLIN, MSN, ANP-BC, ACHPN, FAAN, Individual Subject Matter Expert
STEPHEN FRIEDHOFF, MD, Anthem
SCOTT FRIEDMAN, MD, American Academy of Ophthalmology
SCOTT FURNEY, MD, FACP, Carolina's HealthCare System
STEPHANIE GLIER, MPH, Pacific Business Group on Health
RACHEL GROB, PhD, Center for Patient Partnerships
KATE KOPLAN, MD, MPH, Kaiser Permanente*

ROBERT KRUGHOFF, JD, Consumers' CHECKBOOK
BARB LANDRETH, RN, MBA, St. Louis Area Business Health Coalition

GAYLE LEE, JD, Association of American Medical Colleges

AMY MOYER, The Alliance

MARCI NIELSEN, PhD, MPH, Patient-Centered Primary Care Collaborative

JAMES PACALA, MD, MS, National Center for Interprofessional Practice and Education

DIANE PADDEN, PhD, CRNP, FAANP, American Association of Nurse Practitioners

CYNTHIA PELLEGRINI, March of Dimes

DAVID J. SEIDENWURM, MD, American College of Radiology

WINFRED WU, MD, MPH, Primary Care Information Project

GIRMA ALEMU, MD, MPH, Health Resources and Services Administration (non-voting)

PETER BRISS, MD, MPH, Centers for Disease Control and Prevention (non-voting)

KATE GOODRICH, MD, Centers for Medicare & Medicaid Services (non-voting)

NQF STAFF:

ELISA MUNTHALI, MPH, Vice President, Quality Management
MARCIA WILSON, Senior Vice President, Quality Measurement
POONAM BAL, Project Manager

SEVERA CHAVEZ, Project Analyst

WUNMI ISIJOLA, Senior Project Manager

ANDREW LYZENGA, Senior Project Manager

REVA WINKLER, MD, PhD, Senior Director

ALSO PRESENT:

SOPHIA AUTREY, CMS

JEREMY COLLINS, MD, Society of Interventional Radiology*

AMY MULLINS, MD, American Academy of Family Physicians

KORYN RUBIN, American Medical Association*

JILL SAGE, MPH, American College of Surgeons

RHONDA TALLER, American College of Cardiologists

*** present by teleconference**

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

(8:31 a.m.)

CO-CHAIR WHITACRE: Good morning everybody. I think we're about ready to start. We have a couple Committee Members who will be on the line on and off and I know Kate will be in and out during the course of the meeting. So I hope everybody had a good night. I think we had a great day yesterday and the thought moving forward today will be to continue in the same vein with a very spirited, but collegial discussion of some of the Measures. I think that's, as we've discussed, the real value of the Committee, not just our voting recommendations. Bruce, did you have any additions to yesterday's meeting?

CO-CHAIR BAGLEY: Yes. I thought that the meeting went extremely well yesterday. And just I always like to pause once in a while, is there anything that you really liked about how the meeting went yesterday and is there anything we could do better today, I guess is the real

question? So, any comments on the food, the temperature of the room --

(Laughter.)

CO-CHAIR BAGLEY: -- the conduct from the front of the table? I mean, how did it go?

DR. BRISS: I have one. So, remember that we should do this early and often, so the Staff is to be complimented again, I would say. So remember that they got the MUC list the Wednesday before Thanksgiving. And so this is --

CO-CHAIR BAGLEY: At about 5:45, I think, yes.

DR. BRISS: Yes. I heard it was 3:30. So, don't underestimate how fast we Feds are, Bruce. But the Staff is to be complimented for the quality of the materials given the time, of course, that these things were put together.

CO-CHAIR BAGLEY: Thank you for that.

MEMBER FRIEDHOFF: So, just one housekeeping thing that's slightly confusing. We talk about the Measure numbers and we're going by this sheet and not the online list, and that's

somewhat confusing. And I've kind of been following the online stuff, which is really, really well thought out and nice and laid out for me. So if you could -- I mean, the common dominator is the Measure number. If you could just also state the Measure number, I can stay in sync with what's happening.

DR. WINKLER: Obviously, I think our experience is we'll re-think how we do the numbering. The fact that there were two entries on the discussion guide for each Measure is where we've got to re-think that. But we appreciate it. Okay. Unless anybody else has any comments, we might as well get started. The first topic this morning is interventional radiology. We have seven new Measures that were submitted by the Society of Interventional Radiology.

There is one Outcome Measure that is fully developed, and that's the 30 Day Stroke and Death Rate for Symptomatic Patients undergoing carotid stent placement. Just of note, this is closely related to a Measure that is already in

the clinicians set for asymptomatic patients, so it's really just the other group of patients. The remainder of the Measures are still in development, testing is ongoing and will be completed later in probably the fall/September is the estimate at this point. And most of these Measures are planned to be incorporated into the National Interventional Radiology Quality Registry and data captured through their Structured Reporting Initiative, so, similar to the other specialty societies. I guess we're looking for public comment at this point?

CO-CHAIR WHITACRE: We'll be following the same pattern that we did yesterday, so we'll begin with inviting any public comments, either from people here in the room or, if there are none, from anyone on the phone.

OPERATOR: At this time, to make a comment, please press Star 1. And there are no public comments at this time.

CO-CHAIR WHITACRE: There are no public comments? Okay. Well, if I could ask then, we

have -- let me just review quickly that a couple Measures have already been pulled by Committee Members. And those are, on the printed sheet, Number 5, 6, and 7. Bruce is listed, as well as Stephanie, but, David, I know you also had a concern about those Measures. Are there any Committee Members who would like to pull additional Measures from the list?

If not, perhaps we can begin with the discussion, either Bruce -- oh, forgot, I have to do the consent calendar. So that means the Committee would accept Measures, again on the printed list, 1, 2, 3, and 4 with the Staff recommendations. If there's no objection, then we'll consider those accepted on the consent calendar and then focus on Measures 5, 6, and 7. And it would be for Bruce, Stephanie, and then David.

MEMBER SEIDENWURM: So the first thing I want to do is thank you guys for helping us to recognize the development of interventional radiology as a almost a surgical sub-specialty as

well as a radiologic sub-specialty. And helping to allow my colleagues to develop their discipline in a rigorous way. And I think as the American College of Radiology, Society of Interventional Radiology, Society of Neurointerventional Surgery, the other groups that are practicing in this domain, are really to be commended for trying to go forward with structured evaluation of procedures that even a few years ago weren't ever being done. And so I think that we want to assist them in that endeavor.

The reason that I was concerned about Numbers 5, 6, and 7 on the sheet was because the procedure itself is, and I'm not quite sure whether these are positive things about including them in the program or negative, because they really cut both ways, they're uncommon procedures. They're related, obviously, to the outcomes, but they're not the only things that are related to the outcomes. They might be the tip of the iceberg or the flagship procedure in a

multidisciplinary system of care for these kind of complicated, difficult patients.

And then there was the same discussion we had last time about how detailed we wanted to get in the analysis of uncommon procedures. So the best compromise that I could kind of come up with to square that circle was to retain for further development the patient reported outcomes, because patient reported outcomes for iliofemoral venous stenting would actually wind up being a proxy for patient outcomes for severe post-thrombotic disease and that's an important problem.

And then the improvement in the clinical severity score, which again would be a marker for this kind of interdisciplinary approach to this problem, I wasn't sure if just the assessment of the post-thrombotic syndrome raised the bar quite high enough and if that wasn't subsumed in the others, because we already had an Outcome Measure of improvement. So my recommendation would be to include 5 and 7 and

maybe not so much to go forward with Number 6.

CO-CHAIR WHITACRE: Other comments?

CO-CHAIR BAGLEY: My comments were similar. I wanted to focus a little bit on the idea of, well, first of all, small numbers you already mentioned, but the objectifying and having comparison data for this outcome. I love patient reported outcomes, don't get me wrong, but how do we kind of make sure that this can be objectified and have enough comparison data to be meaningful, I guess was my concern.

MEMBER GLIER: This is Stephanie. My concern was very similar. You actually said what I was hoping to say better than I could have.

MEMBER SEIDENWURM: I doubt that.

MEMBER GLIER: I don't, the way my voice is going this morning. I'm wondering about whether it actually makes sense to move forward with all three of them as some type of a single Measure. Is there a reason that the Venous Clinical Severity Score should be measured separately or is there a way that we could have a

single Patient Reported Outcome or Outcome Measure that includes a patient reported outcome assessment and a clinical assessment using either the Villalta Score or the other score? Do you know enough?

MEMBER SEIDENWURM: Just on the face of it, it seems like if you already were measuring improvement that just measuring the frequency with which assessment was performed would be redundant. So I think that, that might be superfluous. And then the other half of your question, I'm sorry?

MEMBER GLIER: So I'm looking at MUC ID 15-413, which is 13 on the website or 7, I think, on our list this morning, Improvement in the Venous Clinical Severity Score after iliofemoral venous stenting. Does that add substantial value on top of the Patient Reported Outcome Measure or is there a way that we could combine those two into a single Measure with two different scales that both would show improvement?

MEMBER SEIDENWURM: Sure. So, the one

metric is how the patient feels about it, the other is more an objective measure of clinical success. Now obviously, ultimately the goal is to make the patient feel better about their leg and their life, but you also have to know if the procedure itself was successful and if the desired tissue changes were occurring. So I think that they're both important and measuring separate domains of the success of the procedure.

MEMBER GLIER: I agree. I think from a consumer end participant perspective, it would be nice to see those married together so you can say --

MEMBER SEIDENWURM: As a composite?

MEMBER GLIER: As a composite. So there is clinical improvement, but you also see improvement in the functional status and the experience of the patient themselves.

DR. WINKLER: We can add those to the comments for each of them.

CO-CHAIR WHITACRE: Scott?

MEMBER FURNEY: So analogous to our

conversation yesterday about the ophthalmology Measures, this actually is what we asked for yesterday, or at least I did, is assessment of clinical success combined with patient assessment of success, but by validated instrument. So I have a good amount of content expertise in DVT prevention treatment, less in the invasive side, but all of these are subject to very good assessment instruments. So I think having both, can they be combined in a composite, would that be meaningful, I think that it's difficult to do, but they should correlate together. I think they could be redundant at worst, but I'm very happy to see both.

CO-CHAIR WHITACRE: May I make a comment as a Committee Member, just step out of the chair for a minute? One of the issues I see, because I have it in my specialty and I see it happening again and again in different specialties, is saying, well this is great, we've described all the components and possible complications of these either frequent or rare

problems and we should combine patient reported outcomes, and then, we stop.

So, we've made a little bit of a list of things that we might measure and talk about later today and I want to be respectful of everyone's time, I know people have planes to catch, but it seems to me unless we offer some advice to someone about how to overcome that, how do we get from these fragmented multiple small Measures to a more composite clinician/patient reported Outcome Measure, we're maybe not helping the Measure Developers as much as we possibly could. Not that I have the answer, but to me, that's the next step as we move past this, we recommend it be done, but, okay, how? Give me an example, show me how it works, show me how we'd report it. So in, perhaps later at 2:00 or so, when we have the CAHPS discussion, we can revisit that. End of comment. David?

MEMBER SEIDENWURM: Well, not to wax too philosophical here, but I think that the point is that there's a hierarchy of metrics and

they come in layers, right? The patient reported outcomes at the top are for everything and they're comparable and they're validated, but somehow we need to give the physicians, the whole treatment team, the tools to get there. And I think that, notwithstanding the particular use of these metrics and the different payment programs and all that, we need to provide people with the tools that we think are the stepping stones to get them to the whole thing. Because if you just throw this whole big metric at them and say, have at it, we haven't helped and we've abdicated our responsibility in a certain way. So by providing the more detailed tools along the way, maybe we're giving people some help.

CO-CHAIR WHITACRE: My thought was simply that we ask in the future if Measure Developers come with these fragmented tools that they be combined, perhaps with a separate Measure saying, okay, I've got a patient reported outcome for this as well. So it's fine to have three or four Measures, one of them being the Patient

Reported Outcome. I mean, we need that desperately in our field, that's why I bring it up. Reva?

DR. WINKLER: Yes. I'm just wondering if anyone is from the Measure Developers from the Society that had wanted to comment on -- anybody on the phone maybe? I don't see anybody in the room. Just give them an opportunity to comment. Okay. Thanks.

CO-CHAIR WHITACRE: Other comments? This is great, we're going to be way ahead of schedule. Well, if there are no other comments, I think we can proceed with a vote. The first would be on Measure Number 5, this is on the printed sheet. That would be MUC15-411. Scott? Oh, we have to distribute our clickers. Okay, if we can display, then, Measure Number 5. This is Patient reported outcomes following iliofemoral venous stenting, MUC ID MUC15-411. And our choices are Encourage for Continued Development, Do Not Encourage Further Consideration, Insufficient Information.

MS. CHAVEZ: Thank you, Dr. Whitacre. Voting is now open. Terry and Kate, please send your votes via chat and Staff in the room will vote for you via the voting tool. Thank you. Okay. The results for MUC15-411 for MIPS are 100 percent Encourage for Continued Development, zero Do Not Encourage Further Consideration, zero Insufficient Information. So this Measure is recommended for continued development.

CO-CHAIR WHITACRE: So Measure Number 6 on the printed agenda, this is Assessment of post-thrombotic syndrome following iliofemoral venous stenting. That's MUC ID MUC15-412.

MS. CHAVEZ: Okay. Voting is open. Okay. The results for MUC15-412 for MIPS are 56 percent Encourage for Continued Development, 44 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR WHITACRE: The next Measure is number 7 on the printed agenda, Improvement in the Venous Clinical Severity Score after iliofemoral venous stenting, MUC ID MUC15-413.

MS. CHAVEZ: Voting is open. I apologize, it was the wrong slide, so let's start over. Okay, we get a fresh 35 seconds, voting is open. Okay. Voting results for MUC ID 413 for MIPS are 94 percent Encourage for Continued Development, six percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR WHITACRE: Reva?

DR. WINKLER: Yes. I just noticed that in terms of the folks that pulled these, they mentioned it both for MIPS and Physician Compare. And we really hadn't focused in on that, but it would be worthwhile or would be helpful for us, if indeed you do have disagreements with the way we characterize the recommendation for the Physician Compare, the web page versus in the spreadsheet, and as Kate said, everything's in the spreadsheet, but in the web page specifically, please let us know because we will be providing that information to CMS and we want to represent the recommendation of the work here accurately. Obviously, any Measure that isn't

recommended won't have a recommendation for Physician Compare.

MEMBER SEIDENWURM: So, just along the same lines as yesterday, philosophically, this should be available to people who want to look for it, so as long as it's broken down into a form that a sixth grader can understand.

DR. WINKLER: Yes.

CO-CHAIR WHITACRE: Terrific. We'll move on to the next section.

CO-CHAIR BAGLEY: Okay. We're scheduled for a break, but I hope you guys can press on through. We next are going to consider the pre-rulemaking input for MIPS and PC Measures under urogynecology.

CO-CHAIR WHITACRE: It turns out, I guess, we're tallying the votes from the phone and I guess there was a bit of a delay and this is for Measure, it's on the last group, Measure Number 6 on 412. So, MUC15-412, which is Measure 6 on the printed agenda, that came in at 56 percent, apparently with the addition of the

outside votes, that changed the percentages. Would it be reasonable to ask everybody to revote on that Measure and make sure we tally the telephone votes at the same time? So if we can proceed with a revote of Measure Number 6 on the printed agenda, which I'll read to make sure we're clear, Assessment of post-thrombotic syndrome following iliofemoral venous stenting, MUC ID MUC15-412. And we'll make sure that we've tallied, as we move forward, the telephone respondents as well.

MS. BAL: Kate, Terry, and Robert, please go ahead and just chat your votes now while we're getting this ready. Thank you.

MS. CHAVEZ: Okay. We're now ready to vote for MUC15-412, 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient Information. Okay. The votes are in and the results for MUC15-412 for MIPS are 52 percent Encourage for Continued Development, 48 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR WHITACRE: Thank you. I apologize for the glitch.

CO-CHAIR BAGLEY: Okay. In that case, we'll go on to the agenda item marked 10:30 and we're going to look at the Measures for urogynecology. We're going to start with an opportunity for public comment. Is there anyone on the phone with a public comment? I realize that there's a slight disadvantage for somebody who is following the agenda, specifically we're a little ahead of schedule, but I don't know, unless we just sit here and wait an hour, that probably is not going to work. So any other general comments about this -- Reva, do you want to give an overview?

DR. WINKLER: The next group of Measures is around urogynecology. There are five Measures from the American Urogynecologic Society. There is a combination of Process and Outcome Measures that are all still in development.

CO-CHAIR BAGLEY: All right. Well,

just to note, on your agenda, Number 4 has actually been pulled. So, yes, there are six listed, but 4 is pulled. Just so there's no confusion there. And so far we have already pulled 1, 3, 5, and 6 on your agenda. That leaves only 2 that hasn't been. Is anybody interested in hearing a discussion about 2? Seeing none, I'll ask if there's any objection to accepting 2 as a consent calendar? I see none, so let's move on. Stephanie, the Stephanie Show continues.

MEMBER GLIER: The Stephanie Show continues, but I'm wondering if our Lead Discussants also wanted to weigh in on their --

CO-CHAIR BAGLEY: Okay, sure. Thank you for that.

MEMBER LANDRETH: I'm supposed to be talking about Physician Compare, but I actually had some questions about this. Maybe, Reva, you can answer this. It's been 30 years since I've worked in GYN, but when I saw the colpocleisis, I had never even heard of this. So, I went back in

and looked it up on Up to Date and now I understand what it is. I was concerned because I was wondering about how common is this? And I noticed that the Developers didn't really have an indication of how common it was.

So I went into the database that we have, claims database from all of the St. Louis area, and looked for the last four years for this procedure, the CPT Code 57120, and there were 42 cases. But it was, obviously, a primarily under 65 population, so it might not have been representative, because we don't have the Medicare data in there. So it might give you an idea, but for four years, 42 cases is really not that many. And so, how prevalent is this?

DR. WINKLER: I would counter this with the fact that it's most common done in the very elderly --

MEMBER LANDRETH: Right.

DR. WINKLER: -- women who have significant pelvic prolapse who are really not great surgical candidates for more significant

surgery. And this is just done for symptom, to control the prolapse. So, if you didn't have representative numbers from a Medicare population, I don't think it's particularly meaningful, because that's where you're going to see all these patients. This is done strictly for symptom relief in elderly patients who are not good candidates for more definitive surgery.

MEMBER LANDRETH: I was --

DR. WINKLER: And I couldn't find any data on it either.

MEMBER LANDRETH: I was just wondering, there are so many other things that I think that ACOG could be looking at, like what's the incidence of pap smears that are done unnecessarily? What's the incidents of vaginal pap smears that are being done on post-hysterectomy women with no cervixes? To focus on something that I'd never even heard of, and I'm ignorant, but to the exclusion of some of the other things I think that are much more common, it didn't seem to make much sense to me.

DR. WINKLER: I will just point out that these are from a sub-specialty, the urogynecology --

MEMBER LANDRETH: Okay.

DR. WINKLER: -- so they have a very narrow, narrow focus and it is not the breadth of gynecology in terms of their particular interest.

MEMBER LANDRETH: Okay. That makes more sense.

CO-CHAIR BAGLEY: Luther or Jim?

DR. CLARK: No, I was just going to point out that the Urogynecologic Society was in fact in support of these Measures. There was some question in terms of the route as to what the baseline was in terms of what proportion of women really would not be eligible for vaginal hysterectomy. And that was a question, but they were in support. That was my only comment.

MEMBER PACALA: I had a couple of comments in general to tee up discussions. For Number 1 on route of hysterectomy, I just wanted to note that, as you can see, there's wide

variability in the numbers of vaginal versus abdominal versus laparoscopic. And so, while the Measure Developers admittedly say that they're not sure what the right percentage is, I still think it has utility in comparative data and I think even as a practitioner, a practitioner would want to know how I compare to the rest of my peers in terms of the frequencies of these procedures I'm doing.

In that sense, I think it is somewhat parallel to C-Section. And there are C-Section rates and there's wide variability of C-Section rates within practices and across practices. And I think, obviously, within practices it's probably a little bit more significant than across practices because practices see different populations of people. But I ended up thinking about the Measure that way and I thought that if I were a practitioner doing those procedures, I would want to know. And so, I thought encouraging further development of that Measure was a good idea.

In terms of the Number 3, the obliterative procedures, I think we just covered that fairly well. I'm a geriatrician, it's not the most common condition, but it's also not terribly uncommon and it's a patient safety Measure that seems pretty straightforward. So I didn't see too much controversy in that one. And then in 5 and 6, both of those were offering trials of conservative management before a surgical procedure, in the first one, to correct fecal incontinence and in the second one, to correct urgency urinary incontinence. Both of those are interesting in that I think most of the research has shown that conservative treatment can be effective and, obviously, it's safe, so that's a good idea.

I did have some issue with thinking about these conditions, because there are certain conditions, particularly with prolapse, where the prolapse, these conditions can get to a point where it's so severe that conservative treatment is not very useful. So it's sort of like with

BPH, if the AUA score is 15 or 20 in somebody with BPH, then you realize that drug therapy is probably not going to help their symptoms and that they probably need some type of surgical intervention. And so, there might be some colorectal surgeons who specialize in fecal incontinence surgery who only see the worst cases.

So in lots of those cases, they may not have a trial of conservative management because that's already been done or it's just not worth it. So, again, they're going to further develop, it's encourage further development, I think those are good ideas because trying a conservative treatment first is probably a good idea in general. So that's the end of my comments. There wasn't too much disagreement in the few public comments that were received, but ACOG said these things represent good practice and we support them.

CO-CHAIR BAGLEY: Now Stephanie.

MEMBER GLIER: Jim, you teed up my

comments so perfectly, thank you. My first response on the conservative therapy Measures, which also happen to be Documentation Measures, really line up with what the NQF Staff had offered in their preliminary analysis and I think I totally agree with you that we would want to make sure that conservative therapy is appropriate. And even beyond the sort of patient reported outcomes that's indicated here in the NQF Staff response, it would be really fantastic to have a Functional Status Measure here so that you could actually say, this is a candidate, based on the functional status, this is a candidate for conservative therapy, and have a Measure that demonstrates that before you go into something that's more intensive.

Similarly, I think -- I had actually pulled these Measures specifically for the Physician Compare recommendations and when I was thinking about it, it was because I don't think these Measures would be useful for a patient as they are now and I think you guys had recommended

that they go on the spreadsheet, not on the individual clinician website because what is a patient going to do with this information if we don't have something like a Patient Reported Outcome or a Functional Status Measure?

So, to my mind, I think further developing these as they are is not particularly useful, but if we are able to recommend if the Society is able to do some work on a functional status assessment or on a patient reported outcome that could do some shared decision making based on the evidence along with the documentation of conservation therapy as appropriate, that would be very valuable for patients. And, in that case, I would want to see that Measure on an individual clinician website. But if it ends up being something that is not particularly useful for patients, I'm not sure that we should support further development. So that's where my comments lie on those Measures.

CO-CHAIR BAGLEY: Go ahead, Jim.

MEMBER PACALA: Could I ask, there was

a recommendation for the route of hysterectomy that, that be on the clinician webpage and I actually think that's a good idea. I agree with that recommendation, although without some kind of adjustment for case mix, that could be misleading, but I do think that is something that a consumer would want to know.

MEMBER GLIER: And you're doing a great job teeing it right back to me on that one. My comment on that was actually that I think if there's a way, and I know I'm sort of grasping at straws here, but if there's a way to incorporate some shared decision making into that Measure, because we don't know what the right case mix is, I think having some patient preference indicated in the way that the Measure displays would be really valuable and could help us make something presented on the clinician website more useful, to say, yes, my doctor listened to me about what my preferences were, whatever it is, about recovery from surgery or basic risks or the equivalent.

CO-CHAIR BAGLEY: Mady?

DR. CHALK: From the Duals perspective, I wanted to support what Stephanie just talked about. Given that some of these Measures have to do with elderly patients, the shared decision making issue is a very big issue and was identified by the Duals group as a major gap in the way we're thinking about Measure development. So, just wanted to support what you said.

CO-CHAIR BAGLEY: Thank you for that. Other comments? Go ahead, Cindy.

MEMBER PELLEGRINI: So from a purely practical perspective, I'm not sure I'm seeing how the route of hysterectomy Measure is useful to CMS for MIPS because they would have to say, here's how you are going to be judged as successful, right? We're going to have to set a threshold or something like that and if we don't know, if we have really no idea what the right threshold is, how do they do that, right? So how do you even know if you're doing well on this Measure or not? So I do agree that I think it

would be great for the Physician Compare clinician webpage.

And then just a note on the rest of the Measures. I found it really interesting that the ACOG comments were all that this is good gynecologic practice, which, to me, maybe I'm overthinking it, but to me sounded like damning them with faint praise. Sort of, again, are we just measuring normal baseline good practice that everybody ought to be doing or are we actually measuring high quality care?

CO-CHAIR BAGLEY: Kate, did you have any comment about that? Nothing to say about true, true, and related. Go ahead, Scott.

MEMBER FRIEDMAN: I'm obviously not an OB/GYN, maybe we have some people that have expertise, so in 2010, most hysterectomies were not performed vaginally, yet that's the preferred treatment. Can someone elaborate on why we're looking at this Measure at all? Is vaginal hysterectomy the best way to treat this disease? And, if so, why in 2010 are most docs not doing

it that way? My understanding is, it's not necessarily the best way in talking to my colleagues.

DR. WINKLER: Yes. Anybody from AUGS or ACOG on the line? I don't want to preempt that. Okay. I actually just read the recent literature, Scott, so that I can answer it, not from my personal experience, but from what I'm recently reading, is in fact the data does show that there is decreased complications and improved recovery time for the non-abdominal route, whether it's a LAVH or a vag hyst.

The current data actually is the problem and there are concerted efforts by ACOG to promote greater use of vaginal hysterectomy and assisted vaginal hysterectomy. All of the journals I've been getting and only glancing at, I've started reading more detail and you see that this is because of the benefit to patients. And so, this is something they are promoting and supporting and the data does show that it is better outcomes for patients in most cases.

MEMBER FRIEDMAN: Vaginal's better than, not to get in details, is better than laparoscopic, for example, LAVH?

DR. WINKLER: I think the laparoscopic and vaginal are together versus a straightforward laparotomy with hysterectomy.

MEMBER FRIEDMAN: So based on what you just told me, this Measure is incorrect, that vaginal isn't the preferential way to do this?

DR. WINKLER: No, no, evidence base is one thing, current performance is --

MEMBER FRIEDMAN: Well, is vaginal hysterectomy associated with better outcome than laparoscopic, for example?

DR. WINKLER: Those two, I think, are fairly comparable.

MEMBER FRIEDMAN: So should the Measure be rewritten to state that?

DR. WINKLER: We can certainly ask. Like I say, I glanced at the data.

CO-CHAIR BAGLEY: Amy?

MEMBER MOYER: So, I've been trying to

find some data to support this, but I know I've heard this come up as a conversation with clinicians throughout our state about the appropriateness of the hysterectomy in the first place. And, so, we're talking about how to do the procedure, but I'm looking at the Measures in the program and what's out there and I'm not seeing anything that talks about, should the procedure have happened in the first place? And I think that's a question I'd want to answer before talking about how we did the procedure. So it would be nice to see a Measure like that. I did see a lot of kind of more anecdotal news story type things come up, but it feels like there's a perception at least that this is a potentially overused procedure.

CO-CHAIR BAGLEY: Barbara?

MEMBER LANDRETH: Reva, maybe you can help me. Robotic procedures, that seems to be the way that a lot of clinicians in Tulsa are going for hysterectomies. So would those be considered laparoscopic?

DR. WINKLER: In all honesty, I'm looking at the specifications and they've only specified it using the various codes and I just don't know the codes off the top of my head, so I can't answer your question. I mean, we'd have to look those up to see what gets captured.

MEMBER LANDRETH: I can see that the Measure Developers may be wanting to evaluate the use of robotic because presumably it's more expensive. And, again, that's a good question, I don't know, because robotic surgery is now being used much more and is that even necessary?

CO-CHAIR WHITACRE: If I can just ask a question, again, this is just as a Committee Member, does the group of either GYN specialists or urogynecologists or anybody have a registry that's looking at this? The reason I ask that is I'm struck by the way different Measures have been brought to the Committee, we've had what I gather with the ophthalmologists, a registry-based, hey, we've got some data, here's numbers, we've got clinicians engaged, and we're throwing

these Measures forward. And I get a sense that here MIPS is being used as a registry to collect data, which may or may not be inappropriate, I'm just trying to understand how the Measure came forward.

DR. GOODRICH: This is Kate. First of all, Sophia, do we know if they have like a QCDR? They don't, do they? They don't. Okay. So the way these would be used would -- I think they're submitted as registry Measures, what that means for us if we decided to propose them and if we finalize them, they would be then coded into many of what's called the traditional registries, these are the registries that have been run, CE City, there's lot of others, this is even pre-QCDR. So they would be available by probably multiple different registries. There's a lot of registries out there that basically have all the PQRS and would probably have all the future MIPS Measures in there, so clinicians could chose to work with a registry to submit that, that's how that would end up working.

CO-CHAIR BAGLEY: Amy?

MEMBER MOYER: I sit on the Surgery Committee and they recently brought several Measures to that Committee and my understanding from what they said there is they're working very hard to get a registry in place and it sounded like maybe in the next year they hoped to have that up and running.

CO-CHAIR BAGLEY: Other comments? Yes, go ahead, Dave.

MEMBER SEIDENWURM: So it sounds like the way forward here would be to encourage further development with particular attention to the other less invasive routes and, dare I say it, the ones that are the most cost effective.

CO-CHAIR BAGLEY: Jim, go ahead.

MEMBER PACALA: Yes. Perhaps just a consideration of a different numerator. The numerator here was percentage of vaginal, maybe we want to find out what the percentage of abdominals is since that seems to be the one that they're discouraging.

CO-CHAIR BAGLEY: Lower is better.

MEMBER SEIDENWURM: Oh and one other point, just to amplify what Amy said earlier, I think this would be another example of where when we touch on one aspect of a procedure, we ought to look at whether it was indicated, how it was done, what the outcomes were, as well as just the frequency, for example. That we really need to have this kind of pyramid of Measures rather than just look at one snapshot.

CO-CHAIR BAGLEY: Eric?

CO-CHAIR WHITACRE: I would add to that, but I would add cost as well because I think that's very important in discriminating the cost effectiveness of these procedures.

CO-CHAIR BAGLEY: I have kind of a question around that to Kate. To what extent have you seen real appropriateness Measures offered up? Across the board, I mean.

DR. GOODRICH: Yes. We've definitely seen an increase in Appropriate Use Measures over the last couple of years, especially that the

specialty societies are starting to develop and sending in to us. So we are seeing more.

CO-CHAIR BAGLEY: You've let it be known that those would be welcome from anyone?

DR. GOODRICH: We've been pretty clear about what our priorities are, I think we've been clear, you tell me if we're not, and Appropriate Use is always on that list of Measure types we are interested in.

CO-CHAIR BAGLEY: Great. Additional comments on any of these Measures under consideration? Any public comment or comment from the phone on these?

OPERATOR: At this time, to make a comment, please press Star 1. There are no public comments.

CO-CHAIR BAGLEY: Okay. Rachel?

MEMBER GROB: I just wanted to make an observation, with all due respect to everyone, that it's very useful to have the Measure Developers here for some of these questions and I'm just reflecting on the sort of substantive

value of the MAP's deliberations relative to who ends up being in the room. So, I mean, frankly, I'm looking at this vote and I'm thinking, I feel like personally I have insufficient information, but I don't really know whether that means there's insufficient information out there or not. So just as sort of a process point, maybe to hang on to for later, whatever we can do to --

DR. WINKLER: Rachel, let me just make two observations. All the Developers were notified and invited and encouraged to attend. But one of the problems of us being so far ahead of schedule that I'm a little bit concerned about is they weren't expecting it to come up on the agenda until a little bit later. That, I think, is ---

MEMBER GROB: Well, that's kind of worth, that's actually really worth considering. And, again, I don't mean it as a criticism at all of --

DR. WINKLER: Yes.

MEMBER GROB: -- NQF or the MAP or CMS

or even the Developers, but just a reflection as a work group member who doesn't have substantive expertise in a lot of these areas, that it's very helpful to have that dialog because it produces a richer understanding of what the Developer was thinking of.

CO-CHAIR BAGLEY: Let me offer this. If, and then I'll ask the Staff to help us, if someone comes on the line later that we told what time to come on, I'd be pretty open to a reconsideration of things like this. So, I don't think we have to -- we'll be easy about a motion to reconsider, let's put it that way. So if you guys would be on the lookout for them when they come on, or contact them separately if you have that option, that would be great. Okay. Are we ready to vote? Anybody else have any comments? I guess we're ready to vote. The first Measure will be 15-437, route.

MS. CHAVEZ: Now voting for MUC15-437 for MIPS. Voting options, 1 Encourage for Continued Development, 2 Do Not Encourage Further

Consideration, 3 Insufficient Information. For those on the phone, please submit your votes via chat. Thank you. Okay. And the voting results for MUC15-437 for MIPS are 84 percent Encourage for Continued Development, 11 percent Do Not Encourage Further Consideration, five percent Insufficient Information.

CO-CHAIR BAGLEY: Okay. Number 3 on your agenda is MUC15-439, Testing for uterine disease prior to obliteration.

MS. CHAVEZ: Okay. Voting is now open. Okay. The voting results for MUC15-439 for MIPS are 86 percent Encourage for Continued Development, 14 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR BAGLEY: The next one will be MUC15-440 and this is Documentation of trial of conservative management prior to fecal incontinence surgery.

SSS: Okay. Now voting for MUC15-440, 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient

Information. Voting is open. The voting results for MUC15-440 for MIPS are 90 percent Encourage for Continued Development, 10 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR BAGLEY: And the final one will be MUC15-441, Trial of conservative management prior to urgency incontinence surgery.

MS. CHAVEZ: Voting is open. Those on the phone, please submit your votes via chat. The voting results for MUC15-441 for MIPS are 86 percent Encourage for Continued Development, 14 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR BAGLEY: Okay. Well, thank you very much. It's almost time for lunch, Eric.

(Laughter.)

CO-CHAIR BAGLEY: Let's keep on trucking. I mean it's up to you.

CO-CHAIR WHITACRE: Do we have a mechanism either to contact the Developers for the subsequent sections so they know we're way

ahead of schedule? And maybe we should take a couple minutes to do that and see if that's successful? If so, let's take a little break and see if we can resolve the discrepancy in the schedule and planned call-ins.

(Whereupon, the above-entitled matter went off the record at 9:24 a.m. and resumed at 9:37 a.m.)

CO-CHAIR WHITACRE: So, because we were way ahead on the agenda, it turns out that the group from interventional radiology is on the line. Just to let them know, all of the Measures were recommended for further development, except for MUC ID 15-412, which was Assessment of post-thrombotic syndrome following iliofemoral venous stenting. But certainly we would invite you to make any additional comments about that Measure set.

DR. COLLINS: Sure. This is Jeremy Collins with the SIR. So let me just take a quick look at my notes here. That's 412 -- yes, so that Measure was looking specifically at the

Villalta Score, I think, to evaluate the patient reported symptoms and clinical findings that are related to post-thrombotic syndrome. There is a bit of overlap, I admit, with the Measure 413, the Venous Clinical Severity Score.

In our discussions, which included our venous service line, I apologize, the one gentleman who was able to make it from the venous service line had to step into a case and stepped off the phone, they were thinking that combining this in some way with 413 would be reasonable. And we can certainly, once things progress through the process here and we're maybe looking to evaluate the Measure in more detail and specify it, come up with either a combined Measure that has both the Villalta Score and the Venous Clinical Severity Score, or leave as-is based on the comments.

CO-CHAIR WHITACRE: I think that reflects discussion that also occurred at the Committee level. That seemed --

DR. COLLINS: Okay.

CO-CHAIR WHITACRE: -- very reasonable.

DR. COLLINS: Great. Okay.

CO-CHAIR WHITACRE: Super. Were there any other comments that you would like to make?

DR. COLLINS: I had -- yes. One other comment, I noticed that there was a concern that one of the quality of life surveys, the uterine fibroid symptoms score, was something that one had to pay for institutions to use outside the research setting. I just wanted to reassure the group there that individuals who would want to use it for the purposes of quality reporting would have access to it free of charge.

CO-CHAIR WHITACRE: Terrific. Thank you. Well, that's great. Well, thank you very much. I'm sorry that the agenda was a little bit off timing, but we appreciate you calling in.

DR. COLLINS: Great. Thanks so much. Appreciate it.

CO-CHAIR WHITACRE: Thank you.

DR. WINKLER: Is anybody on the phone from the American Urogynecologic Society?

Operator, do you know?

OPERATOR: I don't see anyone online at this time.

DR. WINKLER: Okay. Would you please let us know if anyone does call in from that organization?

OPERATOR: Yes, ma'am.

CO-CHAIR WHITACRE: Well, the thought was that we could change the agenda by taking some of the afternoon items and inserting them at this point, but the feeling was, when Bruce and I talked about it, that our thought processes will be a little bit different and we'll be on a different level, so that it made sense to move ahead with the agenda and to invite the outside groups to make comments, being very willing to reconsider our votes if there are substantive comments. If that's okay with everybody, we'll move on to the next section then. This is the gastroenterology Measures under consideration. And, as always, we begin with public comment. Are there -- oh, excuse me.

DR. WINKLER: Just in terms of the ten Measures for gastroenterology, they're a little bit different even though they're a group of specialty Measures. They are from a practice in Eugene, Oregon and not the specialty society per se. These do address new condition areas, particularly liver disease, and there are several new endoscopy Measures. I think we should take note of the comments that have been submitted by the societies on these Measures.

CO-CHAIR WHITACRE: Please, Kate?

DR. GOODRICH: So I'd like to make a comment, not specifically about these Measures, but Amy reminded me that I should have mentioned this yesterday and I failed to, I'm sorry. So, many of you know that CMS and America's Health Insurance Plans have been working together with some of the professional societies and consumers and practitioners to develop consensus around core sets of Measures in particular areas. The idea being that once we have consensus in these areas -- and these are for existing Measures, by

the way, so we sort of tabled or put in a parking lot thinking about specific gaps and priorities for development just yet. And so there's been a lot of work done over the last 18 months on this.

And the reason I'm bringing it up now is because one of the topic areas that we have developed consensus around is around liver disease. So, particularly hepatitis C, sort of we have it combined with HIV Measures. So, I just wanted to recognize that and have people be aware that, that has happened. We do plan, by the way, to make these lists public. We're aiming for the end of the year, so that's very soon, but our goal is to do that.

And so the idea is that CMS would include these core sets in our relevant programs, MIPS would be a relevant program. I will say that the vast majority of the Measures that are in these core sets are already in our PQRS program and that private payers would similarly use these core sets in their contracts with provider organizations as they come up for

renewal or if there's an opportunity to modify a contract. We have about 70, 75 percent of covered lives represented around the table. So, anyway, a lot of great work that's gone on. NQF has been at the table as well as this has happened.

So, again, number one, I'm bringing it up because I forgot to yesterday in my opening remarks and, number two, given that we're at a topic now that does include an area where we had consensus around core sets, I just wanted to let you know. It doesn't mean that we couldn't consider some of these, we still want the MAP's input, doesn't mean that we're not going to take the MAP's input, but I will also say this process with the private payers and CMS and the other groups is going to be an iterative ongoing process, it doesn't stop now, and so we know that new and better Measures are going to come along down the pike that we'll want to include and may even replace some of the ones on the core set. So it doesn't stop what we're doing now, but I

wanted the group to be aware that this has happened. And happy to take any questions about it, but, again, just apologize for not talking about this yesterday.

CO-CHAIR WHITACRE: Thank you. I have a question, if I could begin? What are the other core sets?

DR. GOODRICH: Sure. So ACO primary care medical home, which really tends to be mostly primary care Measures. Hepatitis C/HIV was one set that was sort of together. GI Measures. And then OB/GYN, medical oncology, cardiology. We also did orthopedics, but there's so few orthopedics Measures, we ended up really just talking about the hospital level Measures, which this is really intended for ambulatory care, the work that we've been doing. So those are the ones. Oh, and pediatrics is happening now, it hasn't -- we're not going to be releasing pediatrics because it's much earlier in its process than the others.

CO-CHAIR BAGLEY: To what extent does

the gastroenterology core set overlap with these recommendations?

DR. GOODRICH: So, I think the gastroenterology core set does not include these on here, I don't believe, and, Amy, you can keep me honest here. I can pull it up, I just don't, in fact I will pull it up, I just don't have it front of me. So these are different from what's in the core set currently.

CO-CHAIR WHITACRE: Other questions? Well, thank you very much, that's very helpful. So if we can get back -- David?

MEMBER SEIDENWURM: Would now be the time to pull for --

CO-CHAIR WHITACRE: Public comment first.

MEMBER SEIDENWURM: Oh, sorry about that.

CO-CHAIR WHITACRE: Reva did quick overview. I'm sorry, we're getting this down. I'm not quite, I'm a slow learner.

(Laughter.)

CO-CHAIR WHITACRE: So now it's time for public comment on the gastroenterology Measures. Is there anyone either in the room or on the phone who would like to make a comment about these Measures?

OPERATOR: Once again, to make a comment, please press Star 1. There are no public comments from the phone line.

CO-CHAIR WHITACRE: Thank you.

DR. MULLINS: So, Amy Mullins, AAFP. And of the Measures that were proposed, nine were on the core set and I appreciate Kate bringing that up. I did have a note in my notes that the MUC Number 230, but I don't know that it is in this section, maybe it's not in these, so that one was on the core set, but I don't see it listed here. Oh, in the next batch? Okay. So that one was in the core set in the -- but none of the ones in this section were listed in the core set. And I have a copy of those, Kate, if you need them.

CO-CHAIR WHITACRE: Thank you. So if

there are no other public comments, I'd like to let the Committee know that several Measures have already been pulled. This is off the printed agenda. And that is Measure Number 2, Number 3, and Number 4, where once again Stephanie will have the floor. Are there other Members who would like to pull any other Measures? David? Peter?

DR. BRISS: I'd also like to pull Number 1, please, in addition --

CO-CHAIR WHITACRE: Number 1?

DR. BRISS: -- to the ones that Stephanie has pulled.

CO-CHAIR WHITACRE: David?

MEMBER SEIDENWURM: I'd like to also pull Number 1, Number 9, and Number 10. Yes.

CO-CHAIR WHITACRE: Terrific. Other Members? Yes, Peter?

DR. BRISS: Yes, without pulling any more off, because I don't think it's necessary, I wanted to hear a conversation, much like I asked for yesterday, about this entire set being sort

of compliance with treatment protocols kind of Measures or standard procedures, standard care, to see whether these really are robust enough to move forward as something that really would advance quality. So sort of a general discussion, I suspect we'll hit that on talking about any of these.

DR. WINKLER: Again, I will just note that as we -- sort of the chronic problem across the whole set of Measures, there was really very little data on current performance to really know what the current problem is or isn't among these topic areas.

CO-CHAIR WHITACRE: Jim, are you pulling a Measure or do I hand it over to Stephanie? Stephanie, I think you're up.

MEMBER GLIER: Do we want to start with the Barrett's Esophagus folks?

CO-CHAIR WHITACRE: We can start with Number 1, if 1 was, I think Peter. We'll just go down the list rather than order in which they were pulled.

DR. BRISS: Yes. So briefly on these, there were a number of issues with the whole suite of endoscopy Measures. And, so, it appears that not a lot is known about current performance, not a lot is known about variation in performance. And, so, there are issues if these Measures go forward that need to be -- that could be further sort of addressed on the science side. On the specification side, a number of the people that commented on these Measures noted correctly that they could be better specified to discourage overuse as well as encouraging appropriate use of endoscopy.

So many of these Measures are specified, I won't get into the Measure specs, details, but they're things like, have you had an endoscopy within the last year? And the endoscopies aren't actually recommended that often, it's often three to five years or something like that. And so you could specify the time courses more precisely to both encourage appropriate use and discourage some overuse.

CO-CHAIR WHITACRE: Stephanie?

MEMBER GLIER: Yes, I'd like to echo that. And I think to the extent that there is the potential for the Society to consider respecifying this as a single Measure of surveillance for these conditions, I think we could still get the data we need to understand better how this is going forward without having many discrete Measures that are not particularly useful in addition to each other.

I wanted to thank the NQF Staff again for their very thoughtful review on the hepatitis Measures later in this set. I really strongly agreed with your comments about how these Measures could be made better, so I did not pull some of those Measures because you had already said the comments that I wanted to. So just verbally endorsing what you had already said. The specific comments that I wanted to make about the Measures were to potentially combine the Measures, but also on the Non-selective beta blocker use, which is Measure 4 on our list --

oh, I'm sorry, one last comment for the Staff. Listed on our agenda, Number 2 and Number 3 are both titled MUC15-221, the second one is 212. You got that already?

DR. WINKLER: That should be 212, the third.

MEMBER GLIER: Yes. So, Number 4 though, the Non-selective beta blocker use in patients with esophageal varices, I think NQF's recommendations already were right on. It's unclear to me how large the performance gap is and I'm wondering again whether it would be possible to develop this as a Patient Reported Outcome Measure or a Functional Status Measure of some sort? And, like I said in the last section, if it is developed that way, I think it would be really useful on Physician Compare. If it is not developed that way, I would recommend against further development.

CO-CHAIR WHITACRE: David?

MEMBER SEIDENWURM: So, this is kind of a general comment about the endoscopy

surveillance colonoscopy. I think that, particularly with respect to Measure Number 1, the endoscopy for Barrett's Esophagus, I think that we could do a lot of mischief here if we went forward with a Measure like this unless it were coupled with an overuse Measure for endoscopy for GERD to begin with, because I think that the problem is that, for many people, the Barrett's Esophagus is a finding with not 100 percent inter-observer reproducibility among endoscopists and pathologists, let's say.

And then the people who -- it also occurs sort of somewhat in the asymptomatic population, the screening population. So then, you start with maybe a procedure that wasn't indicated to begin with, you get to a finding that's of uncertain significance, then you follow it in order to detect a disease that we don't know the treatment helps. So you kind of set up a cascade here. So I'm kind of -- I'm overstating the case a little bit for rhetorical purposes, but not by a whole ton I don't think.

So I think if we were going to do this, we would want to couple it with an overuse metric for GERD endoscopy.

CO-CHAIR WHITACRE: Yes, Jim?

MEMBER PACALA: In Measures 1 through 3, again, the endoscopy Measures, I struggled with this because it seems to me that the American College of Gastroenterology states that these are recommended procedures, yet the comments from the American Gastroenterological Association didn't support them. They didn't specify why they didn't support them. And then the society for the endoscopists themselves didn't support it for the reasons that David's talking about.

And I thought, well, that's pretty powerful. If the endoscopists are saying, this isn't quite settled and this could lead to overuse of what we do, I thought that was a pretty powerful statement. But I really, I'm not a gastroenterologist, so I just had trouble resolving or reconciling what appears to be

differences between the ACG, AGA, and AGSE or whatever. I mean, it was tough for me. Does anybody, can anybody shed any light on that or is it what it appears to be, an internal conflict?

CO-CHAIR WHITACRE: Peter?

DR. BRISS: I can only interpret the text of the comments. It didn't look to me like people necessarily had issues with the Measure concept, they did have issues with implementing a Measure today sort of in a program, given that we don't know much about current performance and the Measures aren't necessarily specified to deal with overuse, for example. So it didn't sound to me like -- I didn't read the comments as being opposed to further development of the Measure, I thought that they did raise some issues that would need to be addressed as the Developer goes forward.

CO-CHAIR WHITACRE: Yes?

MEMBER AVERBECK: So I had a comment about actually one of the comments on the Non-selective beta blocker use. And one of the

comments was, because of the side effects, patients don't take the medication. And I'm unaware of any other Measure where we have used the fact that there are side effects or patients not choosing to take a medicine as a reason not to have the Measure.

CO-CHAIR WHITACRE: Yes, Peter?

DR. BRISS: On that Measure, the issue that one of the commenters raised that I thought was perhaps most germane is that there are multiple equivalent therapies that one could choose and this one is picking one winner out of a stable of appropriate therapies. And so that would have been the primary issue on that one that I'd like the Developers to actually think hard about.

CO-CHAIR WHITACRE: Scott?

MEMBER FRIEDMAN: Again, from a non-GI perspective, is the problem that there aren't enough endoscopies being done or are there too many or we just don't know? And then the other issue is that, do the specialty societies, and

I'm sure there's some overlap, is it that they don't agree with the recommendations and how do you resolve that issue?

CO-CHAIR WHITACRE: Yes, Scott?

MEMBER FURNEY: So, as an internist that deals with gastroenterologists, so I'm not a gastroenterologist, the discussion of Barrett's is a question of overuse. So within the GI community and both reading the comments and from my colleagues, that Measure is something that is, without a Measure of overuse as many have said, is potentially concerning to include as a Measure, could actually increase inappropriate use. The other Measures, I'm a bit more puzzled and the comments are more mixed.

So in evaluating dysplasia for Ulcerative Colitis and Crohn's is an important condition and in reading the comments, it's not clear what the contention is, one society would support, one would not. And that for me, because we don't know the gap in those Measures, I think those two, referring back to the Developers and

actually having them work with the specialty societies makes sense to me. And so my question for the group is, can we get the people who proposed the Measure and are developing the Measure to actually work in a collaborative way with the specialty societies to determine if the Measure can be developed in a more appropriate way?

CO-CHAIR WHITACRE: Yes?

MEMBER FRIEDHOFF: If I take off my primary care hat for a second and put on my payer hat, in terms of potential for underutilization for things like Barrett's for example, sometimes if the recommendation is over a multi-year period, it's a little hard for us to tell because individuals may not have the same insurance over that period of time. But I can tell you that for things like Barrett's and certainly for GERD, we definitely see significant overutilization, and it's very variable, significant regional, even within a region, variation as you'd probably expect for something like that. So I would also

encourage potentially looking at additional Measures around overutilization. And one other quick question, I noticed that AGA seemed to not endorse anything on this list, including the vaccines, which seemed fairly straightforward to me, and I'm curious if there was a hidden message in there somewhere in terms of the development process?

MEMBER PELLEGRINI: So, kind of using your comment as a starting point, I have a more general comment about the public comments that we've gotten here. And I'm wondering, it seems to me, first of all, that it's in some ways wonderful that we get any comments at all because the MUC is open for 15 minutes I think for comment, right, to file. But they are incredibly helpful when we do get them, but some are, of course, much more helpful than others. And I'm wondering if there's any way that, I don't know if this would necessarily be appropriate from NQF, but if even we as a Committee could put out a very brief statement to would-be commenters

about what is.

So for example, a long letter where your position is buried somewhere in about the twelfth sentence is less helpful than a two or three sentence, we support or we oppose and this is why. And from the AGA perspective, saying that they oppose this is kind of helpful, but knowing why would be a lot more useful in, is this an internal conflict? Is this a lack of evidence? Is this the fact that they actually really hate this, but they don't want to say so to some of their members who developed these Measures? I mean, okay, they're not going to say that. But it seems like maybe some very brief parameters would benefit everybody.

CO-CHAIR WHITACRE: Just listening to the discussion, it seems, and speaking just as a member of the Committee, these seem to be nascent, incompletely defined Measures where there's not strong society support where we've had an opportunity to learn how it might be better for them to proceed if indeed these are

important Measures.

One is, we need substantive comments, we need some sense of consensus, we need a sense that perhaps the Measure Developers, if these are a little controversial, need to be here. And perhaps there's a way we would, and I again don't know if this is our role, we have to stay within our lanes of responsibility and so forth, but it would be incredibly helpful to have these people here to help us and it would be very helpful to have more structured comments.

Comments are great, but we could say, they will be easier for the Members to review, and it has to do with simple time constraints, these are part of the Committee. We get the Measures, we have only a certain amount of time, if we're going to digest your point of view, we need it in a structured fashion. I think this is incredibly valuable. I think some of our best discussions are about some of the Measures that we're least comfortable with, so it's always good to have some like this on the list. If they're

all slam-dunk, we don't learn anything. Sorry, end of discussion.

DR. WINKLER: Yes. Just in response to that, Wunmi's over in the back room nodding, it's certainly something we can add to the introduction when we put the MUC list up for comment to give little bit more directive. And that feedback I think is very useful and we welcome it, but I think we can --

CO-CHAIR WHITACRE: Yes, David?

MEMBER SEIDENWURM: Another area that we could encourage the Measure Developers, I think, with respect to these types of things is, if we're going to have a Measure for a procedure in which we're quite sure there's variation in the way the procedure is performed, we know that objectively for colonoscopy and I don't know as much about the data for upper endoscopy, it would also be good to include these and perhaps include a composite with respect to the way the procedure is performed. Was the terminal ileum reached? Was the -- what was the withdrawal time?

I mean, all of the metrics that are employed where there's a lot of variation and we know that there's correlation with intermediate outcome anyway. So I think if we are going to have a metric that talks about some aspect of a procedure and encourages people to do a procedure, we ought to encourage people to do it well. I mean, we don't want people to do more bad anything, we want people to do more good whatever it is.

CO-CHAIR WHITACRE: Luther?

DR. CLARK: Just a point of clarification, did someone say earlier that these Measures were put together by a group of practitioners? And I guess my question there and that may be the source of some of the disagreement, how common is that? I mean, this is a group practice that is submitting Measures that would then be broadly applied and one would assume that there are processes within the structured organizations for which they belong.

DR. WINKLER: I mean, we don't have a

lot of information on who they are, the Eugene Gastroenterologic Consultants and the Oregon Endoscopy Center. The call for Measures that CMS does is open to anyone and so I don't believe there are any particular limits on who could develop. This could be a very large group with a large data structure. It's hard to -- I don't think we know enough about it to say one way or the other.

CO-CHAIR WHITACRE: Yes, Peter?

DR. BRISS: And Measures in general come from all kinds of places, so there are some Measure Developers that do huge numbers of Measures and sometimes there are small boutique shops that kind of own one Measure and there's everything in between.

CO-CHAIR WHITACRE: David?

MEMBER SEIDENWURM: Well, I think that we should evaluate the metrics on their own and the source isn't as important. I mean, I think politically of course, it's to be preferred if the broader community of patients and other

stakeholders, doctors, whatever, approve a Measure and like it, but I think a good Measure wherever it comes from, is something that deserves to be considered.

CO-CHAIR WHITACRE: Yes, Marci?

MEMBER NIELSEN: This may not be the right place to offer these comments, but as we spend so much time giving Reva and her team advice about additional information we'd like and maybe a little bit more of this and maybe a little bit more of that, I'm drawn to the fact that we are creating more problems for ourselves in some regard because we have so much data in front of us to evaluate these Measures that we have become Measure Developers ourselves.

And my suggestion might be, every time we, and maybe we need to have some consensus about this, every time we ask for some sort of new means by which NQF could help us evaluate a Measure, we take something off their list that we didn't find particularly useful because there's such disparity in what we know as we sit here and

evaluate a Measure. If you're not a clinician, I'm telling you, there is medical terminology galore. If we did all of our homework, we non-clinicians, to get to speed, we'd all be doctors.

(Laughter.)

MEMBER NIELSEN: And, as I said before, I'm not good at math.

(Laughter.)

MEMBER NIELSEN: I am good at statistics though, I pointed that out to somebody yesterday. My other point would be, I can't imagine that Reva's not sitting here going, really, you know what, if you had just done A, B, and C, you would be able, you any of us, to better evaluate a Measure. So one thing I'd maybe invite you all to do, is to say, to maximize your participation on the MAP, our suggestion is, and not just like, you guys give us so much information, it is astounding what a terrific job you do on that front and I am so grateful for it, but I think you should start bossing us around.

If you want to maximize your time at a MAP meeting, here are the three things you must do, here are three additional things that would be of help, particularly if you are doing the facilitation, because I can now talk about advanced directives until the cows come home, but did you notice we didn't even talk about it, that was the thing I studied up most on. So I don't know, Eric, I know you asked us to have some like brainstorming and we're in the middle of the Measure discussion, but because I have a flight at 3:00, I wanted to make sure I got that in there. Thank you, thank you, thank you to NQF Staff for the job you do. Let's take some stuff off your plate as we're putting stuff on and then start bossing us around. The end.

CO-CHAIR WHITACRE: So we have on the gaps list, lighter load, better instructions, and little math, before we come to the meeting.

(Laughter.)

CO-CHAIR WHITACRE: Yes, Peter?

DR. BRISS: For the endoscopy Measures

in particular, I suspect we might be ready for some decision making. And I would say that it's sort of separate from the issue of the Developer. These are kind of specialized Measures for certain kinds of procedural people, but we haven't thrown out Measures previously in this meeting because they're kind of specialized for certain kinds of procedural people. But we've identified a number of things that if these things went forward for further development, the Developers would have to deal with. So they're all sort of issues about how the Measures are specified and how they would need to get a little bit broader input so that we didn't have such a hung jury and so we could probably try to get some decision making on it.

CO-CHAIR WHITACRE: Do you have comment first, Sophia?

MS. AUTREY: Yes. So I wanted to go back to the question about the people that actually submit the Measures to CMS. And really, Reva, answered the question beautifully. This is

exactly what we do, we receive information and Measures from a number of organizations and societies. What we would hope is that those societies or those organizations would work with the specialists before submitting the Measure, but we have received Measures in the past from educational institutions and they did not talk to the specialists that actually do it and so when we have the Measure in front of us, the specialists are like, no. So, that's why we bring it here.

(Laughter.)

CO-CHAIR WHITACRE: That's a great explanation, thank you. I agree with Peter -- oh, sorry. Yes, Gayle?

MEMBER LEE: I just had a real quick question for Sophia. Because I am confused about what the dynamic and what's going on between the specialty society and the Measure Developers, did the specialty society come to CMS directly at all and raise any issues or can you shed any light on what's going on here between the Developers and

the society?

MS. AUTREY: Well, if the Measure Developer didn't contact the specialty society prior to developing these Measures, then the first time that the specialty society saw it would have been when the MAP actually put it out for comment. So, we have no idea what those conversations were prior to the submission.

CO-CHAIR WHITACRE: Well, I tend to agree with Peter that we've sort of come to a mind on the endoscopy Measures and if it would be okay with everyone, before we address the hepatitis Measures, that we move ahead with a vote on the first four Measures. So if there's no objection, if we can go ahead and prepare to do that. Sorry, Stephanie?

MEMBER GLIER: Can I just clarify? I agree, I think we came to a consensus. I want to be clear what I think that consensus is, which is that the Measure either needs to be revised to include an overuse component or it needs to be paired with an overuse Measure.

CO-CHAIR WHITACRE: We have limited choices on how we vote.

MEMBER GLIER: No, I agree. I'm not saying --

CO-CHAIR WHITACRE: Yes.

MEMBER GLIER: -- we should change the voting, I just want to be clear so that when the Developer is looking at our feedback or when CMS is going back looking at our feedback, it's clear that even if this Measure is continued developed as it is, if we say Encourage for Continued Development, that's not what we mean, we mean it has to include overuse.

CO-CHAIR WHITACRE: I think hopefully the comments will reflect exactly what you have said. I think that's where we have to come to some agreement in how we send that message back. Yes, Scott?

MEMBER FURNEY: So, as relatively new to this Committee, it's not clear to me, and I've had discussions with a number of people, what happens to the recommendation to encourage

continued development? Because if that does not return here and our comments are -- so what I'm hearing is, this needs to be substantively revised or abandoned. So, I guess what I'm looking for is guidance on if we all believe that the Measures in their current state are flawed and we vote 1, Encourage for Continued Development, that doesn't reflect the discussion. If it's continued in the current vein, it would be incomplete and I think most of the Committee would not agree with them. So it just seems like a simple question, should I vote 1 or 2? Because I'm hearing 2 because we don't control the output, unless I can better understand the output once we're complete.

CO-CHAIR WHITACRE: I think these are great questions and they're certainly going to come up on my list of gaps, because I don't have a complete understanding of this. So, great question, needs to be discussed later, I'm not sure I have the exact answer. Yes, Scott?

MEMBER FRIEDMAN: That's a great point.

Just to embellish this and get on new also. So, a lot of the Measures are good, they just need tweaking a little bit. And that's Encourage for Continued Development. A lot of the Measures, they bring up a point, but they probably need to go in a different direction, so do we need to add a fourth category? Instead of Encourage for Continued Development or Do Not, we don't want you to stop using it, but it needs to be tweaked significantly. So maybe the NQF should consider a fourth category moving forward for next year.

CO-CHAIR WHITACRE: Peter?

DR. BRISS: Yes. And what I was going to say was that, I agree that we may need a finer way of feeding back information, because I don't think I've heard anybody say that a well-constructed endoscopy Measure would be a terrible thing, right? And so I don't think the message that we're trying to send is, endoscopy Measures are non-starters, they're public health and clinical care trivial, and we don't want to see anything like that back, right? And we don't

have any way to finely say -- we don't really have a clean way of saying, a well-constructed endoscopy Measure would be fine and this isn't it, right?

(Laughter.)

CO-CHAIR WHITACRE: Yes, Rachel?

MEMBER GROB: Yes, I'm just put in mind of the analogy of when you either review or submit for review to a peer reviewed venue that the options that you get are accept with revisions, which would be like Encourage for Continued Development, but then there's the very important revise and resubmit, right? And you will always be told when you revise, that does not mean that we will accept it, but we've given a lot of thought to this and we've given you a lot of feedback and we need to see this back.

So, I just offer that as an analogy that may resonate that may resonate with a lot of people in the room because I think what we're saying with these is, revise, like seriously revise, and resubmit. But I agree that it's not

clear then how to vote. I will just offer that I've been taking those, as I think has been suggested, as a 2, because I don't think it's clear enough to us what the Developer will do and whether it will come back to the MAP in a way that's satisfactory. But I think we need to revise the categories.

CO-CHAIR WHITACRE: These are great comments. There's also an ambiguity in my mind as to whether or not we are really addressing this vote to CMS and whether or not it should be considered for these programs, which is ultimately I thought the purpose of the Committee. We've taken on the task, and I believe rightly so, of providing feedback to the Developers, because we're saying, hey, we'd really like to see better Measures and we think you're going in the right direction or you're not. So there's a dual purpose and that's why I think there's some ambiguity. I'm seeing this as a message to CMS saying, I wouldn't even consider this for any programs the way it is, or, yes, if

they did a little better and they got back to you with revisions. So there's ambiguity as to the audience. Peter?

DR. BRISS: And I don't want to speak for my CMS colleagues, but I will say, so I'm an old member of the Committee, and so CMS pays very careful attention I think to what the MAP says as a general principle. And so I find it unlikely if you voted 1 and considered that a revise and resubmit, with advice to CMS and advice to the Developer, I think it seems to me to be unlikely that CMS would know that all that conversation happened and just kind of blindly accept a set of unchanged Measures that we'd said might deserve some further development.

CO-CHAIR WHITACRE: Yes, Beth?

MEMBER AVERBECK: So, listening to the conversation, I'm going to use, I think we're being very Minnesota nice because we really want this to succeed, but I think to Peter's comment, if it's significant revision, the conversation may reflect don't encourage further consideration

with this particular Measure and the comments around the revision. So that's just an observation.

CO-CHAIR WHITACRE: I want more bad Measures because we have better discussions.

(Laughter.)

CO-CHAIR WHITACRE: I think it's great. No, that's true. Yes?

DR. ALEMU: I have a question. We are spending a lot of time on Measures which are not completed, which are not fully tested. We're discussing here and taking a large amount of time. Would it be, from CMS perspective, better to have Measures which are already completed, which are fully tested, so that we say, okay, this Measure is relevant to our programs? If there is something which needs to be changed on those fully specified and completed Measures, then it would be helpful to have the discussion, I would say, at the same time.

Even if Reva may answer my question, Medicaid has proposed to Measure Developers to

come in contact with them before they start developing their Measures, I think, if I'm not mistaken, so that they get ideas on how important the Measure is, whether there are other related or similar Measures, and so on. But even if CMS says, this Measure is not applicable to our programs, but the Measure Developers can use the Measure for their specific societies for quality improvement purposes. So I think I just need clarification why we need to discuss a number of Measures which are not fully tested and completed.

CO-CHAIR WHITACRE: Sophia, if you could help us out and then, Reva, if you could speak from the NQF standpoint on what the MAP does.

MS. AUTREY: Okay. So, from the beginning of when Measure development starts from the Measure Developer side, we actually reach out to Measure Developers, especially the ones that have Measures currently in the program, and let them know that we are here, if you have concepts,

please discuss those with us. We're here, available for any feedback. Some Measure Developers take us up on that, some do not. And those that do actually get much valuable feedback from us and then go back and change it, revise the Measure as needed, based on the feedback that we provide. So we do not get that from all of the Measure Developers, but we do offer that.

So, in the instance that a Measure Developer submits a Measure through our call for Measures and they've started testing, because we've actually changed that, we used to accept Measure concepts, that was not good, you guys didn't have any idea what was going on when it came to you. So we stopped doing that. We actually moved it towards, it at least had to go through some phase of testing first. It didn't have to be fully developed because what if you get to that fully developed phase and it comes through the MAP, you've wasted a lot of time and money. But if you started alpha testing, realized it needed to be updated and changed, at

least you haven't gone fully through development before it is submitted to MAP. So we have the requirement that it at least had to go through alpha testing before you can submit it and we thought that, that was a nice medium.

CO-CHAIR WHITACRE: Reva first perhaps and then Steve?

DR. WINKLER: Yes. From NQF's perspective, the MAP work is very specified towards supporting CMS, the Measures Under Consideration list, to provide the pre-rulemaking input. From NQF's endorsement side, we only are looking for fully tested Measures to go through the endorsement process. We also offer a lot of up-front technical advice that different Developers take or not depending. And we do a lot of outreach and, frankly, spend a lot of time at it. And so I think there are a lot of resources, but it's highly variable on what's going on out there.

So, one of the things that we are spending a lot of effort on is integrating the

MAP and the endorsement processes to the degree that we can. But as you see in this particular set of Measures, very few Measures have been through the NQF endorsement process, so we don't have the benefit of the information that would have been generated during that evaluation. So it's a very dynamic, changing environment with lots and lots of needs on the ground.

CO-CHAIR WHITACRE: Steve?

MEMBER FRIEDHOFF: It's maybe a newbie question and maybe something that's sort of been asked another way, but there's two tracks it feels like. For Measures that are not fully baked yet, we're either encouraging or we're not encouraging for further development. And then there's ones that are fully developed and we're voting to support or not to support. So I guess my question is, it makes sense to have that, you don't want to be wasting a lot of energy and resources if it's not going to pass the initial muster for encourage or do not encourage, but if we are encouraging something or we have a vote

like however this vote turns out, is the implication that a not fully baked initiative that we're supporting or encouraging further development will then eventually come back for a support or do not support vote?

Because I'm not sure I fully understand then, I mean, I understand why you would want to try to save the resources, but it seems to me in the end, if some of the encourages are not going to come back, then to me, I think I'd only want to see the fully baked ones as support or do not support, unless they come back again.

DR. GOODRICH: Yes. We talked a lot about that, whether or not we should only put Measures on the MUC list that are fully baked. We find that we are getting a lot more Measures coming our way, particularly from the specialty societies, and we thought it would be very helpful to get some direction from the MAP, not just for us, but also for the Developers, as to whether -- I mean, these Measures are expensive

to develop, so we thought it would be very helpful to get that kind of direction.

So, my experience with being a Measure Developer is also that, when you have something this early in the process that they often do change considerably after you go through testing. And so any Measure that comes to the MAP at any point along the way, if it's undergone substantive changes, we do bring it back. Measures that don't undergo substantive changes, we are not legally required to bring it back, but I don't even know if we've been in that situation yet where we've had Measures that have come so early that then we haven't brought back because they haven't undergone other changes. I don't know if we've done that or not.

But certainly, I will tell you my personal opinion is that the information we're getting about the direction of these Measures could really help make a lot of these Measures better and we'd like to see that happen and so they would then, I think a lot of these would, if

the Developers take the recommendations of the MAP and go back, would then need to come back through because they would be so substantively different I think.

MEMBER FRIEDHOFF: And I'm not discouraging --

DR. GOODRICH: Yes.

MEMBER FRIEDHOFF: -- bringing through the ones early like you're doing, I guess the follow-up question was then some assurance that they would then come back if there --

DR. GOODRICH: Yes.

MEMBER FRIEDHOFF: -- to your point, there was a significant change.

DR. GOODRICH: Yes, they would.

CO-CHAIR WHITACRE: Are these questions for Kate?

MEMBER PELLEGRINI: Yes.

CO-CHAIR WHITACRE: Okay. Please, Cindy?

MEMBER PELLEGRINI: So, Kate, would it be possible or practical or helpful in the future

then, could we distinguish within some of these Measure sets, would there be a way to say, these are the ones that are fully baked and are really genuine candidates for the next round of MIPS or whatever program we're talking about? So these are the fully baked Measures and these are the half-baked Measures?

(Laughter.)

DR. GOODRICH: I think we can talk through that with the NQF Staff how to distinguish that. We do have, within the information we send to NQF, at least within our internal spreadsheets, which I think is what you guys get, where they are in development. So maybe we're just making assumptions that everybody can see exactly where they are in development and maybe we need to just have something that makes that crystal clear.

CO-CHAIR WHITACRE: Peter, was it a question again? I have two other people, David and Stephanie.

DR. BRISS: It was.

CO-CHAIR WHITACRE: Yes.

DR. BRISS: It was sort of on this point.

CO-CHAIR WHITACRE: Go ahead.

DR. BRISS: So a comment on this point, as you're thinking about this in the MAP, the other thing that you might think about is, Kate and I and Girma, and several of the other people around the table probably, were involved in developing a cholesterol Measure, I just want to give you sort of the other side of this story. We've been working on a cholesterol Measure since 2013, before the last set of guidelines changed. And we couldn't quite get it into this process this year because people didn't feel like it was baked enough.

And so what that means is that I've got to keep explaining to my boss that when the guidelines changed in 2013, and we started sprinting pre-guideline change in 2013, the earliest we can get a new Measure into programs for a universally accepted high priority area

that everybody's sprinting on is 2017. And so, one of the things that people are trying to balance is this issue about trying to get committees enough information and trying to shorten some of these ridiculously long time lines.

MEMBER SEIDENWURM: Yes. Well said. So speaking as a Measure Developer for the moment here, we find the process of these kind of multiple sort of parallel pathways to be extremely helpful because, as was mentioned, the human and financial cost of developing a Measure, even on a topic that might be important to a specialty society that seems kind of trivial to a group like this, it's hard. And to put in all of that effort, and people really kind of have an emotional commitment to these things after they've been working on them for quite a while, and then to find out that the whole concept just isn't interesting to the program, would be bad.

So I kind of like the idea that things are able to bundle up in their kind of nascent

states and then people can get feedback. Well, yes, we're really interested in endoscopy, but just not this way, is a good piece of feedback to get before a lot of money and time are spent. So I actually like the idea that the endorsement people kind of know what the MAP is thinking, the MAP gets to know what the endorsement people are thinking, that the Measure Developers get to know what CMS is thinking, and they get to know what a community of their peers is thinking, and what the other stakeholders, who they might not always have access to. It's actually very, very hard as a Measure Developer to get patient and payer representatives to participate on these panels, that's a lot of P's. So this is really -- you guys are helping, we're helping I think. So I kind of like it the way it is.

CO-CHAIR WHITACRE: Stephanie, did you have something?

MEMBER GLIER: I was going to say almost the same thing. Sort of from the other perspective, from the whole program perspective,

one of MAP's roles is to flag gaps for CMS and I think having this kind of a conversation about where the Measures aren't exactly fitting what we want is helping inform our conversation that we're going to have, probably not at 2:00 or whatever time is on the agenda, but a little later today about where we really see the gaps and the types of Measures that we'd like to see, that I think can be helpful, both to the Measure Developers who are paying attention to what we say, I don't know who they are, and also to Kate, who's thinking about where the program can go and what is going to be most useful coming from a body like this. So I think it's still a valuable conversation, even if at the individual Measure conversation level it feels a little off.

CO-CHAIR WHITACRE: Rachel?

MEMBER GROB: It's just to circle around on some of these points that have been made, I also really agree with what you said, David. I think that it's a very valuable role for MAP and for this group to be giving this

feedback. But, again, and, Kate, you were out of the room for part of this discussion, although I know your colleagues will relay it, I think the discomfort that I have felt is that I think there's a little -- we're still needing to align how we describe these votes with an evolving understanding of the MAP's kind of role in informing ongoing development.

And so, I'm wondering, as a question for you, whether given all of that's been happening over the last two days, you're going to take the feedback, whether the preponderance of us voted 1 or 2 as sort of a little bit of feedback, we have a little bit of feedback here or we have a lot of feedback here if it's 2, right, because we're not really in a position given that these are half baked to kind of -- it's not so much a referendum as a discussion. Is that how you're understanding it?

DR. GOODRICH: Yes, it is. And this has evolved over the last couple of years really where these kinds of Measures have been coming to

this group in particular more and more. I think in the first year or two of the program, this really didn't happen. And so I think we're all learning sort of what's the best kind of input for you all to give us about those. I think, for us, it goes beyond just these three categories, so if you're saying, Encourage for Continued Development, maybe we could think about if that becomes sort of with a condition, kind of like we have conditional support, is there other conditions associated with that? Something to think about for later, for next year.

But I think what's underneath, the conversation and the details that are underneath each one of those recommendations, is what we would want to take back in our conversations with the Developers to say -- I mean, I'll just tell you, personally, I've agreed a lot with what, like personally, with what the MAP has said around of these different Measures in terms of combining Measures and making a composite or incorporating shared decision making, very

difficult thing to do, all those sorts of things make all kinds of sense. So I think we would take these back to the Developers and say, hey, this is what we heard, we think that this actually really strengthens the Measures, let's work together on this.

CO-CHAIR WHITACRE: Well, that's great. Hopefully we're about ready for a vote then on the first four Measures. But I have to let you know and apologize that I made two mistakes in the course of this discussion. One is, I inadvertently characterized a group of Measures as not being good, that was in levity and that was to point from our internal discussions, and that's not the way we communicate a message. I apologize.

Second is that I neglected to agree to the consent calendar. We have some Measures that have not been pulled and we did not by consensus agree to accept those. And those are Measures 5, 6, 7, and 8 on the printed sheet. So if I can trace back and ask that we agree as a group that

those would be accepted as part of the consent calendar, my next move would be then to ask if we could vote on the first four Measures and then come back for a discussion on 9 and 10.

So we agree to accept via the consent calendar 5 through 8? If we can move on then to a vote on 1, 2, 3, and 4, I would make the point also that on the printed paperwork, Measure Number 3 is actually MUC ID 15-212, not 221, and you'll see the correct number on the screen. So let's begin with Measure Number 1.

MS. CHAVEZ: Okay. Now voting on MUC15-208 for MIPS. For those on the phone, voting options are 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient Information. Voting is open. Okay. The voting results for MUC15-208 for MIPS are 33 percent Encourage for Continued Development, 62 percent Do Not Encourage Further Consideration, five percent Insufficient Information.

CO-CHAIR WHITACRE: The next Measure

would be Number 2 on the printed agenda, Surveillance colonoscopy for dysplasia in Ulcerative Colitis, MUC ID MUC15-221.

MS. CHAVEZ: Voting is open. Okay. The voting results for MUC15-221 for MIPS are 23 percent Encourage for Continued Development, 73 percent Do Not Encourage Further Consideration, five percent Insufficient Information.

CO-CHAIR WHITACRE: The next Measure, Number 3, is Surveillance colonoscopy for dysplasia in colonic Crohn's Disease, MUC ID MUC15-212.

MS. CHAVEZ: Voting is open. And the voting results for MUC15-212 for MIPS are ten percent Encourage for Continued Development, 81 percent Do Not Encourage Further Consideration, ten percent Insufficient Information.

CO-CHAIR WHITACRE: And, lastly, Number 4, Non-selective beta blocker use in patients with esophageal varices, MUC ID MUC15-209.

MS. CHAVEZ: Voting is open. The voting results for MUC15-209 for MIPS are 23

percent Encourage for Continued Development, 73 percent Do Not Encourage Further Consideration, five percent Insufficient Information.

CO-CHAIR WHITACRE: Great, thank you. If we could move on then to a discussion of Measures 9 and 10 on the printed agenda. This is Screening endoscopy for varices in patients with cirrhosis and Screening for Hepatoma in patients with Chronic Hepatitis B, which were pulled for discussion. I can't remember exactly who pulled them. David, was it you?

MEMBER SEIDENWURM: I pulled the one, Screening for Hepatoma. There's a couple things about this that I think the Committee should consider and maybe CMS should consider along the way. The first is that the way this is specified, it includes screening with CT and MRI along with screening with ultrasound, and the cost difference is high, the radiation, especially since the hepatoma type protocols involve multiple phases and so that's a pretty big exposure to radiation. And presumably this

is an ongoing thing that would be a long-term process, multiple procedures, in a sort of low risk, well, it's an elevated risk population, but the absolute risk isn't super high. So that's something to consider.

Now, I think I know why they specified it that way, because they didn't want someone to get an ultrasound if they'd already had a CT or an MRI for some other reason, right? So I kind of get that, but there must be a way to thread that needle or there might be a way to thread that needle. And, then -- that's a technical point, but the real big issue is, we don't really know if this does any good or a lot of good in terms of the actual outcome of the patients.

We do know, as a fact, that we do get smaller, earlier, lower stage hepatomas when we do this, and I've personally read hundreds of these and I've found one hepatoma and I felt really good about it. But what I don't know -- and we do know that finding things at the earlier, well, we do know that when they present

at the earlier stage that they have a better outcome, but what we don't know is if the ones we find screening get you to the better outcome, and we also don't know if all of the hemangiomas and other things that we find along the way mitigate that.

So it's rather like the discussion that we had before about prostate cancer, that we have this thing that we can point to people who we think we've helped, but we're not really sure. So I think we have to really consider this carefully in the overall context of care and really where the data are. And it seems to me that this is a common enough disorder, particularly in some of the Asian countries where there are advanced medical systems that can study this question in detail, and it sort of surprises me that we don't have proof that this works yet. And I'm wondering if we want to encourage something like this before we really know that.

CO-CHAIR WHITACRE: Thank you. Did you have a sense of why there were no public comments

on that? I would have thought the radiology societies would have said there's no documented advantage for screening or perhaps maybe they didn't want to throw rocks, I don't know. Okay, sorry, just wasn't sure. Question?

MEMBER SEIDENWURM: Maybe because it was over the Thanksgiving weekend.

CO-CHAIR WHITACRE: Scott?

MEMBER FRIEDMAN: So I'm looking at the public comments, there is consensus that the American Gastroenterologist Association and the American Society of Gastrointestinal Endoscopy don't endorse it. So I don't think it gets any clearer than that, so who likes the measure? If their own docs don't like it, representing the specialists don't like it, who likes it?

CO-CHAIR WHITACRE: Peter?

DR. BRISS: These two measures essentially look to me like they have all the problems that we had in the first set of measures and even less evidentiary basis.

CO-CHAIR WHITACRE: Any other

discussion? If not, we'll proceed with the vote. This will be first on Measure Number 9. This is Screening endoscopy for varices in patients with cirrhosis, MUC ID MUC15-251.

MS. CHAVEZ: Voting is open, and for those on the phone, voting options are 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient Information. The voting results for MUC15-251 for MIPS are zero Encourage for Continued Development, 100 percent Do Not Encourage Further Consideration, zero Insufficient Information.

(Laughter.)

CO-CHAIR WHITACRE: Okay. Last measure is Number 10, Screening for Hepatoma in patients with Chronic Hepatitis B, MUC ID MUC15-217.

MS. CHAVEZ: Voting is open. Okay. The voting results for MUC15-217 for MIPS are zero Encourage for Continued Development, 100 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR WHITACRE: Well, that

concludes the gastroenterology measures. Perhaps we can track back and see if anyone is on the line for the previously presented measures on urogynecology. Operator, is there anyone on the line waiting to comment on those?

OPERATOR: We just have some CMS and NCHPC online.

CO-CHAIR WHITACRE: Great, thank you. Let's move on.

CO-CHAIR BAGLEY: Okay. For those of you who are following us on the agenda, I hope you enjoyed your lunch.

(Laughter.)

CO-CHAIR BAGLEY: We'll proceed with the measures under the miscellaneous topics. And, Reva, do you want to set this up and then we'll have some public comment?

DR. WINKLER: Yes, this one is the grab bag. There are onesie-twosie measures of a wide variety of topics, so we kind of put them all together. There's no other relationship among the measures except that, so they pretty much

have to be looked at not as a group, but as a collection of individuals. And there is a good mixture of types of things in it. For instance, we have the first measure of the depression utilization, this is an Outcome Measure. This has been in PQRS for a while. It's an NQF-endorsed measure; we know a lot about it.

Then, we see again the measures you talked about in the MSSP, the PQI 91 and PQI 92. These are measures which we had talked about previously. As I mentioned, both of them, they're still being developed, the risk model, and when I updated the discussion guide, I updated it in the MSSP, but it looks like I didn't update it here. My bad; I'm sorry about that. But, again, we should be consistent across them, but these are essentially the same kind of measures you've talked about previously.

We do have some interesting new measures. One Potential Opioid Overuse, again, there are some existing measures around opioid use in the clinician set. This would be

potentially an added measure. There is also a measure of HIV screening for patients with sexually transmitted diseases. So, again, both of these two -- the opioid and the HIV screening -- are still in development. There is another measure still in development for anesthesia, anesthesiologists on corneal injuries that were not diagnosed in the post-anesthesia care recovery unit, so an anesthesia complication measure -- if you will -- for a wide variety of patients undergoing surgery.

And then there are two measures for audiologists, which are, of course, clinicians that are involved in the measurement programs, and there are two measures still in development that would apply to audiologists. And then, again, on the list is the same ischemic vascular care composite measure that we talked about in the MSSP being under consideration also for the MIPS program. So it is a bit of a grab bag, so we kind of put them all together at the end.

CO-CHAIR BAGLEY: Okay, thank you. I

think the next is to have some public comment. Amy, I see you queueing up over there.

DR. MULLINS: So I wanted to speak about the paired depression measure. Specifically, in the Core Measures Collaborative, we had a lot of discussion around depression and depression measures. And we chose two different depression measures; we chose NQF Measure Numbers 710 and 1885. One of these -- I mean, these are not those measures. I think Depression Remission at Twelve Months is depression measure 710, but the ones it's paired with are not 1885.

The other thing I wanted to speak to is we did a lot of weeping and gnashing of teeth and compromise around depression, and it probably took 18 months to get a Core Measure Set because of the depression measure. And the problem with the remission measure is that it is asking for a PHQ-9 score of less than five. And when I was in practice, I had a lot of patients that came in and they would have a PHQ-9 score of over 20, and to get them to a ten was a huge success. Getting

them to less than five was going to be virtually impossible, so asking for a depression remission at six months with a PHQ of less than five and then again at 12 months with less than five would be really, really difficult. And to put this as a composite measure is going to be a challenge. And so, I would recommend that this not go in the MIPS program and, instead, use the core measures that the work group decided on after much, much deliberation. Thanks.

CO-CHAIR BAGLEY: Okay. Did you have a comment, Eric?

CO-CHAIR WHITACRE: No.

CO-CHAIR BAGLEY: Okay. I guess we're open now to other comments. Why don't we do an extraction first? Because we're going to -- and would anybody -- as a courtesy -- like to extract Number 1?

MEMBER NIELSEN: I would.

CO-CHAIR BAGLEY: Okay. All right. Oh, I'm sorry, they should be on your agenda. Number 3 has been pulled -- 7, 8, and 9.

MEMBER GLIER: And since I'm the one who pulled 3 and we talked about it yesterday, I'm happy to unpull 3, unless somebody else wants to talk about it.

CO-CHAIR BAGLEY: So anybody else can pull it. Would you like to pull 4?

MEMBER PELLEGRINI: Yes, 2 and 4.

CO-CHAIR BAGLEY: So 2 and 4? Okay. So, remaining on the consent calendar, I have 3, 5, and 6.

DR. WINKLER: I just wanted to clarify --

CO-CHAIR BAGLEY: Please.

DR. WINKLER: -- that the preliminary analysis should be changed to match what it was for MSSP. All right. So as part of your consent calendar so that the two are consistent. All right.

CO-CHAIR BAGLEY: One of the things I was going to do with the consent calendar this time particularly is to review the recommendations. So would you help me find a

discrepancy if there is one?

DR. WINKLER: Yes.

CO-CHAIR BAGLEY: Okay.

MEMBER GLIER: And is 3 still on the list, or is 3 pulled?

CO-CHAIR BAGLEY: Three is not currently pulled. Do you want it pulled?

MEMBER GLIER: Yes, sorry.

CO-CHAIR BAGLEY: Okay. It's now back on the -- so now I have 5 and 6 on the consent calendar. Going once, going twice. Okay, absent any other hands, we're going to leave 5 and 6 on the consent calendar, and unless there's any objection, we'll accept those as recommended by the staff recommendation. Okay. Let's go to Number 1. And you've heard Amy's conversation, other comments?

MEMBER ADIRIM: I have a question. This is Terry.

CO-CHAIR BAGLEY: Go ahead.

MEMBER ADIRIM: So within MIPS, are there any other depression measures? And, if so,

what are they?

DR. GOODRICH: So, there's the 710 --

MEMBER ADIRIM: Okay.

DR. GOODRICH: -- is in MIPS. Well, it's in PQRS.

DR. WINKLER: Yes. They can pull up the list.

DR. GOODRICH: Oh, okay.

DR. WINKLER: I was going to say, go ahead and pull it up.

DR. GOODRICH: And I think there's 0418, which is screening with follow-up plan, has been in there for a while.

DR. WINKLER: This is the spreadsheet that you have as the framework that has all the measures listed out that are currently in the programs. So we'll just try and grab that and pull it up.

MEMBER GLIER: And can I clarify, Amy, I don't know if you are -- I'm sorry, I should have this list, but I don't. Did you say the Core Measure Set currently has 710 and 1885? And

to clarify for those of you who don't have the QPS pulled up in front of you, 1885 is depression response at 12 months progress towards remission. And maybe Beth is well positioned to talk about those measures briefly, since she belongs to that organization.

CO-CHAIR BAGLEY: Marci, I think you were next.

MEMBER NIELSEN: Thank you. I share the same concerns that Amy has, but I do want to underscore -- as I mentioned yesterday -- how incredibly important these behavioral health measures are. So, understanding that we've got some other measures in place, and we've got this work that is happening and hopefully announced by the end of the year on a Core Measure Set, an additional item that I might flag that we've not talked about before -- and it's very hard structurally to get at -- but we spend lots of time focusing on individual disease measures without recognizing that that's not really how diseases manifest themselves in people in that

the comorbidity -- people having multiple things going on at the same time -- is what often is the reason why a patient can't "comply" with what their physician or their nurse practitioner is asking them to do.

So, some place in the record, I just want to reflect that some of the complicating factors of doing measurement development well is that we don't have many measures that relate to multiple comorbidities, of which behavioral health -- depression in particular -- would be at the top of that list.

CO-CHAIR BAGLEY: Other comments? Go ahead, Beth.

MEMBER AVERBECK: Just a question on the way the measure is proposed is that either remission at six months or at 12 months? I just was trying to understand. Yes, I've got the specs pulled up. It looks like it's either at six months or 12; see, we get a credit for either one is the way I'm reading it.

And in response to the comment

earlier, certainly responses improving by 50 percent, remission is an absolute value under five, and obviously remission is harder to achieve than response. I think it depends on, is the goal of the measure to see improvement, or do we really want to push how many patients do we get in complete remission -- understanding that, that's going to be a lower amount? So I think that's just something to take into consideration.

CO-CHAIR BAGLEY: David, you're next.

MEMBER SEIDENWURM: Sure. So, I just pulled up the survey and to get a score of below five, you have to answer Not at All to -- in the last two weeks -- little interest or pleasure, feeling down, depressed, hopeless, sleep disturbance, feeling tired, appetite, feeling bad about yourself. So I think that given also the fact that you have the choice between Not at All to get your points and maybe if the MUC were two days longer, we might not score. I wonder if that's the -- sorry, MAP.

(Laughter.)

MEMBER SEIDENWURM: I wonder if that is the right metric. And I don't treat depression in my practice, but it seems a pretty high bar, and I'm not sure how good of a metric that would be.

CO-CHAIR BAGLEY: Jim, you were next and then Amy.

MEMBER PACALA: Five is the cut-off for the screen. That's why they're using five, I think. So, again, to go from 20 to five -- or to go from eight to five -- is a very different clinical situation.

CO-CHAIR BAGLEY: Amy?

MEMBER MOYER: I was just going to say, it's my understanding this is an incredibly well validated and accepted tool, and we don't really need to rehash it here. The data that collected for this -- if I'm understanding correctly -- you can calculate all these measures, so the burden is the same whether you're collecting the remission or whether you're collecting the improvement. I'm usually all about fewer

measures and measure parsimony, but in this case, I'd hate to see us lose the more ambitious measure at the expense of going for the others if the burden is the same. This is an area where we could display all these things without additional data burden on providers.

CO-CHAIR BAGLEY: Winfred?

DR. WU: I just have a question on the core measure collaborative and what it's charged with and what the implications of that group's findings are with respect to CMS programming.

CO-CHAIR BAGLEY: Kate, do you want to --

DR. GOODRICH: Sure. So, the commitment that we and the private payers have made is that we will implement or, for us, we have to propose measures, so we can't, of course, say what we would definitely finalize, but that we would propose the measures that are in the core set. And that does include removing measures under those same topics that may already be in the program, for example. And private

payers have made a commitment to doing the same thing through their contracts. So, that's really what it means.

CO-CHAIR BAGLEY: Scott?

MEMBER FURNEY: Echoing Amy's comments, if the burden is the same for collecting the information and our goal is remission --- which may be unrealistic for a proportion of the patients -- what we really have is a concern about risk adjustment. So, I'd like to think at least briefly about the downside risks of having a measure that is more aggressive. And the more aggressive the measure, the more risk there is that patients who have treatment-resistant depression, unless there's a risk adjustment, would have difficulty accessing care. So that is my only concern about setting a high bar.

In other words, if we were all seeing in primary care the average depressed patient, we should all have the same number -- if we work hard enough -- who get into remission. But there will be a selection bias in treatment-resistant

patients who are the sickest of the sick, may have difficulty because providers -- once there's a financial incentive -- may avoid those patients. So my only concern about the measure is that unless we have a risk adjustment for treatment-resistant depression -- which is a pretty advanced state to be in as a measure -- then we are building in a disincentive for the sickest patients.

CO-CHAIR BAGLEY: Mady?

DR. CHALK: And there are a lot of patients, I've looked at what the exclusions were here, and the only exclusions -- or the primary ones -- have to do with people in nursing homes or with other major diagnoses. But there are a lot of patients, such as disabled patients, who will be depressed and will continue to suffer from some level of depression and are never going to reach less than five on a PHQ-9. And I would be concerned that those -- I want to make sure that those people can still get treated appropriately if we implement this.

CO-CHAIR BAGLEY: I think from my clinical background, I think that people with three or more episodes of depression over their lifetime are, at least in our minds, are considered chronically depressed and may never reach the level. Let me offer something that might be worthwhile considering, I think that there isn't anybody around the table that doesn't think this is important and that remission is important.

I think I hear the problems, number one, with harmonization. In other words, they all ought to be the same. And number two, with a concern about setting a specific number as the target. And that probably needs to have some careful scrutiny. So, one of our options is either to support or conditional support, based on those kind of comments. Is that right?

DR. WINKLER: Yes, definitely.

CO-CHAIR BAGLEY: Go ahead, Steve.

MEMBER FRIEDHOFF: Yes. I agree with that, and I think that one potential way that

developers can look at it, and I'm sure that there's others, are based on PHQ-9, there's also standard ranges from mild to moderate and moderate to severe and severe. So maybe a measure like mild or moderate getting to a target of five, moderate to severe and severe getting to a target of five, that's sort of inherently risk adjusted. I'm sure there's other approaches like that, that could be used, but to your point.

MEMBER FURNEY: I was just going to, I think, Steve just covered that to some degree. I'll just add that if an Improvement Measure, really we should be able to get 80 percent of patients with moderate depression, and the severes will be happy to get them to the mild to moderate range, then some version of an Improvement Measure would, I think, meet the intent. But, I mean, I would agree that this is an incredibly important measure, I don't want to have it lost in the conversation, but the measure probably needs some improvement.

CO-CHAIR BAGLEY: Beth, you're next.

MEMBER AVERBECK: Being part of the measure development in this area, the conversation was around obviously a goal of remission with a response also as a kind of intermediary goal, recognizing not everyone would get into remission. And that's why it was a 50 percent response rate, instead of looking at the category. So that was discussed, but that's why we went with a response rate. I mean, I do like the suggestion, if -- this is a very important topic and is one of our options to say, support and look at the response rate as opposed to remission, at least in the initial stages, as more people are used to using the metrics. And, Amy, you're right, the measurement burden isn't different, I mean, you collect at different data points, it's a PHQ-9, and so there's no added burden for doing that.

CO-CHAIR BAGLEY: Jim?

MEMBER PACALA: I just wanted to chime in about the concerns about unintended consequences for adverse selection. I take care

of a lot of immigrant patients in Minneapolis who have been tortured and have life-long, years long pattern of depression and PTSD, and so I would be judged on this. And we've got team care and we're doing our very best to care for these patients, but it's a big challenge, certainly, to get their PHQ scores below five. And I would hate to see anything that would discourage a team to care for these patients. Do we have any idea whether measures like this are actually creating adverse selection? That they're serving to drive providers away from the patients who most need care? Do we have any sense of that out there?

CO-CHAIR BAGLEY: Scott's got his hand up; he's got all the answers.

MEMBER FURNEY: So, I can only point to the literature. It's been years since I read it, but in Great Britain, the implementation of their payment for value system, which now has 15 years, that's one of the first things that was commented on. In the system that I represent, 650 primary care physicians -- just in the discussion of

putting intent on quality measures -- I'm seeing patients moved around so much that I'm actually developing a retention measure, a percent having to be retained in practice of diabetics because of my grave concern about the balancing measure needed to prevent patients from being moved around.

I'll make one other -- sorry, Amy, I think I'm more cynical than you, one other very cynical point. The people in this room are self-selected and selected for good reasons to be leaders in their field. We have to remember these measures are then taken and distributed across a large population of physicians who will have varying degrees of interest in them and varying degrees of motivation. So, I think we have to think about unintended consequences, I see them regularly in my attempt to regulate quality in a large system.

CO-CHAIR BAGLEY: Beth, you were next.

MEMBER AVERBECK: I think our experience in Minnesota has been that most

systems have gone to looking at PHQ-9 as a vital sign for patients and so being more aware of it in collaborative practices with behavioral health, which is a scarce resource in our state. So, I think maybe that some of the local context might be different, but I think we've seen it certainly raise awareness in looking at how we do more system, team-based care to address it.

CO-CHAIR BAGLEY: David, you were next.

DR. ALEMU: Yes. I have a question. Is the goal stated in this measure -- I mean, to achieve it -- is it really difficult? Is there any literature or number that tells us that the goal is not achievable when it comes specific to this measure? And I don't want to get this measure lost; it's a very important public health issue. And the components are indicating those fully tested and they are being used. So is there any information that tells us that the goal is not achievable by using this measure?

CO-CHAIR BAGLEY: Can anybody kind of direct their comments on that specific question?

DR. ALEMU: Because at the beginning, the first speaker told us that -- from the practical point of view -- it was difficult to achieve what is really intended here. So, I would like to get information about that. And I don't want this measure to get lost because it's really a very important issue.

CO-CHAIR BAGLEY: Beth or Amy, do either one of you have any --

MEMBER AVERBECK: Yes. I was actually trying to look it up. I know there is variation, I think, for the remission, it's been anywhere from 8 percent up into some 25, 30 percent for remission. I remember when we did optimal diabetes, we started at 4 percent and we're now nearing 50 percent -- that's taken a number of years -- but certainly there's variation in the results. But so far, I know like 75 percent probably isn't achievable, but there is a range.

MEMBER SEIDENWURM: Yes. I wanted to go back to the issue of adverse selection. I think that there are some areas where you want to

discourage adverse selection, like this one, and I think that there are some areas where what's called adverse selection is actually proper care. And I think we want to distinguish among the clinical situations in which -- I'm trying to think of a very extreme example -- perhaps some cardiac surgical procedure in some moribund patient who's outcome is unlikely to be altered in a significant way, well then, what's called adverse selection is actually a desirable thing.

But I think for a condition like depression, we want to be very, very mindful of that, and I think we would want to err way on the side of getting people into treatment. And if so, if there were a way somehow of collecting the data, but maybe the way to do this would be to mandate the collection of the data, use it for the improvement, and then calculate remission rates as perhaps a quality improvement goal or something like that. Maybe we could get all of the richness of the information without taking the risk.

CO-CHAIR BAGLEY: Marci, you were next.

MEMBER NIELSEN: Actually, I think Gayle was next.

CO-CHAIR BAGLEY: Go for it, Gayle.

MEMBER NIELSEN: Sorry.

CO-CHAIR BAGLEY: Marci, would you turn --

MEMBER NIELSEN: My hand is just outstretched more.

CO-CHAIR BAGLEY: Yes, please turn off your microphone when you're not speaking.

MEMBER LEE: I just had a couple points. And one is, I think, as I think Scott pointed out, the risk adjustment is really important. In addition to the comorbidities, I just wanted to point out also the sociodemographic factors as being really key, particularly with this population. And the other question I had is we were talking about remission rates, and I guess I'm just wondering -- and there's probably the folks that have the expertise in this area -- is what percentage of

patients never come back, I guess, where you don't get that follow-up six month score or 12 month score when you're looking at the rates? Because I'm guessing that that probably occurs quite frequently as well.

CO-CHAIR BAGLEY: Eric, you were next.

CO-CHAIR WHITACRE: I think there was -- did you have a response?

MEMBER AVERBECK: Yes. I think what it's led to is development of registries and availability of doing PHQ-9s online or by phone. And so that's one of the things -- because you're right, if they don't come back, and some people won't come back, but it allows itself two more convenient ways of reaching patients, too, so it doesn't all have to be office-based. But I think those are the system changes that we've seen to try and make sure that we follow up with patients.

CO-CHAIR BAGLEY: Now Eric.

CO-CHAIR WHITACRE: I just had a question, this is really directed to CMS --

Sophia, if you could help us out. I've lost track of where in MIPS we will have reporting for basically credit and performance, where outcomes and benchmarks will be important, and where we're going to get credit just for the sake of reporting. It's a little bit of the old PQRS versus performance issue. I just don't see -- and it's probably just me, but I've lost track of where that is in MIPS.

MS. AUTREY: Okay. So we have a component, the CPIA, which is where the performance is really going to take shape. But reporting would be under the quality component. So if we could separate it out that way, that's probably where it would be, where the reporting would be under the quality component, and then the performance would be under the CPIA.

CO-CHAIR WHITACRE: So, are we -- it used to be that we had credit just for reporting.

MS. AUTREY: Yes.

CO-CHAIR WHITACRE: That's gone?

MS. AUTREY: No longer. Yes, that's

gone.

CO-CHAIR WHITACRE: All of these will then be tied to a performance number?

MS. AUTREY: Yes.

CO-CHAIR WHITACRE: Wow. Okay. So that number is really important I guess. That's a very critical part of the measure then as you see it. Thank you.

CO-CHAIR BAGLEY: Scott, you were next.

MEMBER FURNEY: Wanted to make a comment primarily around what the expected outcomes of adverse selection is, and I'll use an analogy in diabetes. So, if you have an average A1C controller composite, then the impetus will be for primary care physicians to refer out those diabetics or to not have them retained in their panel, which is potentially a good thing. Patients that are poorly controlled diabetics potentially should see an endocrinologist, although many of the endocrinologists do not believe they can be controlled because it's for other reasons -- sociodemographic factors.

The point of that being, it has to be equal in the comparison. So primary care physicians can be judged on the same composite; endocrinologists need a different composite. So I think part of the measure development and implementation has to be comparing like specialty if there's not a risk stratification. If there is a risk stratification, then it is more of an equal playing field and it needs to be based on comorbidities and socioeconomic status, and that is not an easy thing to do.

The implication for the psychiatric measures is very similar. We can all expect in primary care to get a certain percentage of remission. I think the benefit of choosing a more aggressive measure or metric is that we will actually have a much more concerted effort to get the patients back into the office, do more motivational counseling to get them on more aggressive treatment, so I think that is all a good thing. And as we get the treatment-resistant depression, those then will be referred

to a scarce resource in psychiatry. So I think there are potential benefits, I think the concern about risk adjustment has to be addressed, or at least that like specialties are judged the same way or that adverse selection will be a major issue.

CO-CHAIR BAGLEY: I'd like to get a couple more comments, and then I think it's time for a vote. I think we're kind of all saying the same thing to some degree. So, Marci?

MEMBER NIELSEN: Thanks, Bruce. I agree with Scott that there are a couple of different ways to improve this measure, and one is risk stratification. Another is ensuring that we're looking at specialties differently. But I want to come back to something that Kate underscored, and Scott made a point about this, which is when Medicare all by itself has a set of measures that aren't adapted by the private payers, and those measures don't seem to be particularly meaningful or valid to the clinician offering the services, that is when the practices

are inundated and frustrated and don't understand the meaning of our work, because we've just given them one more thing to do.

So the importance of the Core Measure Set is that we've got a potential alignment between the private sector and Medicare deciding to use the same set of measures, and the extent to which that core set is applicable to multiple different specialties. And on top of the core set, we have specialty driven measures that, again, are meaningful. But that parsimony piece, Helen corrected me yesterday when I said, let's take a deep cleansing breath and what we're trying to do is have measures that mean more and fewer measures.

I know she said that's not true, I am going to push back and say: how could it not be that we want fewer measures? How could that be true? We've got a zillion different measures of a zillion different things. We are wanting those measures to be more valuable, but if part of the goal isn't to have fewer measures, then I think

we're missing the forest through the trees here. And so a measure like this -- which is well intended -- isn't where we need it to be if it's going to require the PHQ-9 to be at five and we can't track improvement over time and we can't risk-stratify.

So, my question gets back to something we were all talking about, which is: what happens if we vote this down? Are we voting this down with agreement that we're sending this on for future development and we'll have all of these comments? Or is the better strategy to vote this up, recognizing that there's an opportunity to change the measure? I am still unclear about --

CO-CHAIR BAGLEY: I'll just remind that if you look on the screen, you do have the opportunity to have conditional support, and the conditions would be the discussion we've just had. So --

MEMBER NIELSEN: Okay.

CO-CHAIR BAGLEY: -- since this is a fully-baked measure --

MEMBER NIELSEN: We can --

CO-CHAIR BAGLEY: -- we have a little bit different in the option list. Amy?

MEMBER NIELSEN: Got it.

DR. WINKLER: I'd also like to add, it's an NQF-endorsed measure, which means your feedback can be taken back to NQF in terms of our annual review of the measure to take another look as per specific feedback from the MAP to the endorsement process, please take a look at those issues, we think they're very important about this measure. So, those are some of the issues. But this measure isn't in development, if you will; it's more just feedback about existing --

CO-CHAIR BAGLEY: Right. We're not voting anything down here. We don't really -- okay. Amy?

MEMBER MOYER: And you both just made the point I was going to make -- that this is a fully baked measure, it has been through the NQF endorsement process, where I'm sure they talked risk adjustment ad nauseam about it and it met

their criteria and was endorsed. So, I mean, it's been through that really big, robust discussion.

CO-CHAIR BAGLEY: I hear you calling the question. Let's vote. You have before you the Measure MUC15-928.

MS. CHAVEZ: And voting options are 1 Support, 2 Conditional Support, 3 Do Not Support. Voting is open. Work group members on the phone, please submit your votes via. chat. Thank you. Okay. The voting results for MUC15-928 for MIPS are 32 percent Support, 69 percent Conditional Support, zero percent Do Not Support. So the vote is Conditional Support.

DR. WINKLER: And I just want to be clear that we do know what those conditions are. I think they've been enumerated a couple of times. All right.

CO-CHAIR BAGLEY: Okay. It was my oversight; I didn't give the opportunity for the lead discussants to speak before we started this. Do any of you have anything to say? By the

nature of this list, we're going to kind of take them one at a time anyway and vote on each one, so if you have comments, this might be a good time to do that. Winfred, did you have any comments?

MEMBER KOPLAN: On this specific measure that we just voted on, or later measures?

CO-CHAIR BAGLEY: Well, later measures because it's a little too late on the one we just voted on.

(Laughter.)

MEMBER KOPLAN: Right. Okay. I just wasn't clear.

DR. WU: And, Bruce, should we just go this measure-by-measure then, so I guess we'll comment on PQI 91?

CO-CHAIR BAGLEY: I think that actually will work better.

DR. WU: Yes.

CO-CHAIR BAGLEY: Yes, right. So, you can get in the queue any time you want.

DR. WU: Sure. Well, I'll just lead

off by, yesterday I believe we voted this for MSSP as Encourage Continued Support. And I think kind of in light of trying to align the different programs, I think that it would make sense to continue with that current recommendation for MIPS.

CO-CHAIR BAGLEY: All right. Let's go to Number 2, and, Cindy, you were the one that extracted that?

MEMBER PELLEGRINI: I'd like to talk if I could about 2 and 3 together, because all my questions are the same. These are two, we had a little conversation about this yesterday, two population-based measures measured at a rate per 100,000. And they seem like very valuable measures from a public health sense, but I just don't understand really how they are applicable in a program like MIPS. How doing population-based measurement and then attempting to apply it to hospitals or practices works from a practical perspective. So if Sophia could help us with that, that would be great.

MS. AUTREY: So, one of the requirements in the legislation for MIPS is that we actually have a number of population-based measures included in the program. So in that vein, we are trying to look more broadly at measures that deal with population-based conditions and issues. So, to address your question of why it's important legislatively --

MEMBER PELLEGRINI: Okay.

MS. AUTREY: -- that's why.

MEMBER PELLEGRINI: I agree it's important, I just don't understand from a pragmatic point of view --- if I'm a provider in the MIPS program, and let's say I'm in independent practice, I'm a singleton practitioner -- how does this apply to me? How do I get measured against it?

MS. AUTREY: Right. And that's something that we are actually looking at with attribution as well as looking at geographical coordination and comparisons. So, we haven't really vetted all of that out as to how it would

be attributable to individual clinicians. But not just for the individual clinicians, but also clinicians that are in facilities and how we would have those measures be utilized in facilities and the attribution to those clinicians as well. So, we are still looking at that, but that is the reason why we started to look at population-based measures.

MEMBER PELLEGRINI: Right. I mean, I think the measures make sense from a measure perspective, but without understanding how the attribution's going to work, I have a hard time recommending that it be added to MIPS.

DR. WU: My understanding is that actually PQI 91 and PQI 92, some components of those are actually part of the VM program. Is that correct? And, if so, clearly there's some precedence as far as how this is applied -- maybe not at the individual provider level, but across a larger number of group-based providers. So I'm curious as to here, given that, what's kind of CMS's perspective on being able to just drill

that down further and how that approach might go?

Sure, I mean, do you feel reasonably confident that -- given that this is already in use in the VM program, where we're looking at groups of providers -- that we'll be able to reasonably measure this at the individual clinician level? And also I'm curious to hear if there's been any feedback as far as group-based providers in the VM program as far as concerns one way or the other with respect to PQI 91 and 92?

MS. AUTREY: Okay, thank you. So one of the things we've been doing is actually working with the staff at VM to see how or the impact of utilizing this measure in the data that they've gotten back from it. So, we are working with them on this to be more clarifying in how we can implement it in MIPS. So, we are utilizing that.

CO-CHAIR BAGLEY: Questions, comments? Anybody on the phone with a comment? All right. Are we --

MEMBER PACALA: I just wanted to reiterate my concern yesterday about Number 2, PQI 91, about a potential adverse effect of promoting antibiotic overusage for bacterial pneumonia and UTI.

CO-CHAIR BAGLEY: Could that be a condition? Okay. Well -- all right. This is not that kind -- okay, great. Oh --

MEMBER GLIER: I'm sorry, just to clarify. Can the staff, can you guys remind you us how we voted on these for the Shared Savings Program yesterday? Were they both Encourage for Continued Development?

DR. WINKLER: Very strongly encouraged further development.

CO-CHAIR BAGLEY: On both --

MEMBER GLIER: Yes.

CO-CHAIR BAGLEY: -- is that correct?

DR. WINKLER: Yes, on both. Both were the same.

CO-CHAIR BAGLEY: Without -- go ahead, Amy.

MEMBER MOYER: Sorry, just a point of question. So the PQI 91 is currently endorsed, but not specified at the individual clinician level?

DR. WINKLER: No, it's not an endorsed measure because this is a composite. Components may be -- and we've got them specified in the description -- but not the composite. We've never seen the composite per se. And the composite itself is undergoing change and further development of a risk-adjusted method.

MEMBER MOYER: Okay. So, should it be a Conditional Support?

DR. WINKLER: We just said -- my bad, I'm the one who goofed. I changed it for MSSP, but I didn't change it for MIPS.

CO-CHAIR BAGLEY: Okay. So you'll see the options that we have on the screen in terms of voting. So, without further comment, I guess we're ready to vote. And this would be for Number 2; it's MUC15-577.

MS. CHAVEZ: Okay. We're now voting on

MUC15-577 for MIPS. And for those on the phone, the options are 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient Information. Voting is open. Okay. And the voting results for MUC15-577 for MIPS are 95 percent Encourage for Continued Development, 5 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR BAGLEY: Yes. With your permission, I'd like to ask for a vote on Number 3. I think it was unclear whether we had it on or off the consent calendar, so if you don't mind, we'll just go ahead and vote on that. Any further comments on Number 3 on your agenda before we proceed to a vote? A lot of similar comments to Number 2. Okay, let's go ahead and vote on Number 3; that would be MUC15-576.

MS. CHAVEZ: Okay. Now voting and the options are 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient Information. Okay.

And the voting results for MUC15-576 for MIPS are 90 percent Encourage for Continued Development, 10 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR BAGLEY: Okay. Let's go on to Number 4; that would be Potential Opioid Overuse. Who pulled that? Oh, go ahead, Barbara.

MEMBER LANDRETH: I agree wholeheartedly with the idea of preventing opioid overuse. I want to make sure -- based on some of the comments that came in here -- that we are consistent, because one of the commenters said that CMS defines high risk of opioid abuse as 120 milligrams, and this measure says 90 milligrams. So just so that it cannot confuse, we need to have a consistent milligrams in whatever we use.

MS. AUTREY: We did go through a revision once we received internal comments when it got HHS clearance. And I think that there is still some degree of changes with the guidelines as well on the level. So, we are still accepting any comments or any valid reasons for what that

level should be, but we did change that while it went through the internal review.

MEMBER LANDRETH: On the same point then, I wanted to make sure that whatever is included as the exclusions is a complete list, because I see what you're including right now as conditions that would be really egregious, like sickle cell, that you would have significant pain. And I know that's kind of a fine line to walk, but as primary care physicians or providers, if we're still being asked to provide adequate pain control and being judged on that, I want to make sure that the measures that were excluded are comprehensive.

And then, third, the thing that I'm actually seeing in practice is that many of my counterparts are saying, I don't want to deal with this anymore; I don't want to deal with my patients who have opioid problems, and so they're referring them out to pain specialty. And while, like Scott said, that's good -- and his analogy was serious diabetics get referred to

endocrinology, which is a good thing, once you get referred out to pain management, it's a whole different ball game.

In terms of the monitoring process, you have to go -- a lot of times it's way across town -- there's very few pain management providers, at least in our town, you can't always get in. And, like this little 75 man said to me, I think he had a little bit of low back pain, and he was going to the pain management specialist faithfully, and it was costing him $35 or $45 every time, every 30 days, to pee in a cup and get his drug screening done. And that was a financial burden for him. So, we brought him back in the practice, we changed him to Tylenol 3 versus a Schedule 2, and that enabled him then to stay with us. But I just want people to be mindful of that additional burden that may not necessarily be on your radar.

CO-CHAIR BAGLEY: Peter?

DR. BRISS: So, we think this is a really important measure addressing an important

and emerging public health area. So, as you go forward with presumably developing or evolving a measure, there's probably work that can be done about justifying the dose and duration that you choose. We favor closer to 90 than some of the other alternatives that have been proposed because of the epidemiologic data of the risk of overdose with dose that sort of does this. So we favor closer to 90, but it needs to be well justified.

We would -- one of the things that comes out in the TPHA comments in particular that is sort of about how narrowly or how expansively the measure is defined, one of the things that TPHA proposed was sort of limiting the measure to people that are seeing multiple providers. And while it's true that seeing multiple providers is an additional risk factor, at high doses even people that are seeing a single provider are at higher risk. So we don't favor narrowing the measure in that kind of a way.

Finally, we would favor a more

parsimonious set of exclusions, because remember you're trying to prevent overdoses, right? And so, the truth is once you get -- there are a couple of exclusions on the list that are sort of unarguable and probably -- palliative care and cancer are certainly unarguable exclusions, everything else I think might be open for discussion.

CO-CHAIR BAGLEY: Steve?

MS. DAHLIN: This is Connie Dahlin. I just also want to speak about that.

CO-CHAIR BAGLEY: Connie, Steve is next and then you'll be on.

MS. DAHLIN: Okay, thank you.

MEMBER FRIEDHOFF: Thank you. Completely agree with the measure and everything you just mentioned as well. And no surprise to anyone in the room as, again, as putting my payer hat on, I can certainly provide lots of data on risk adjustment, specialty adjustment that shows incredible variation out there. So I fully support this. The one caution is that in terms

of posting this on Physician Compare, I think for patients who are doctor shopping for opioids, it could be a very effective tool.

(Laughter.)

MEMBER FRIEDHOFF: So I might not go that way. Thank you.

CO-CHAIR BAGLEY: Okay, Connie, you're up.

MS. DAHLIN: Thanks. So I just wanted to kind of follow up with some of the statements. So this one is really difficult. I mean, the palliative care and cancer piece is obviously an exclusion, but what's also sort of happening is that to the point -- and I can't remember who just said it, is when people get to certain doses, there's a lot of primary physicians who are saying, I'm not going to prescribe any pain meds and I'm going to try to get anybody else to write them because I don't want to do it.

And, so, it might not be palliative care patients that are even being referred out, it's just people who start to need more pain

meds, which we know with certain conditions they do and that they've been evaluated. They just start to be either never prescribed because people look at these doses and think, oh my God, they're going to die, but we know that if people are on chronic opioids, they get used to them. And, so, how do we -- this measure really is worrisome because I think we're not thinking about like with the patients who are on opioids.

So if it said like patients who are on opioids who've just had surgery, that they get one dose and they need to be closely monitored after 90 milligrams and really that's great, but I think the sense of once somebody gets on opioids, maybe they go to a pain specialist who gets a regimen, but then they have to go back to their primary provider so that we don't develop this culture of opioidphobia. I know that it's a health crisis and I get all that, but we're sort of swinging the pendulum back now that where the people who actually need these meds are not.

And I get the point about doctor

shopping, I'm very concerned that we ever post who's doing what with this because that's really scary. Because what's happening right now where I work in a practice, is as a palliative care specialist, anybody who's been on methadone maintenance, if they get admitted to the hospital and they're on methadone, I'm getting a consult, which is just not appropriate. It's because the team is like, well, we're not writing pain meds.

So I just want to be very sensitive to all the pieces that happen with a measure like this, that it sort of encourages this lack of responsibility to kind of figure out and do a really thorough pain assessment and what are the appropriate drugs, and also thinking about how do we incorporate both pharmacological and non-pharmacological, which I think we all would agree, it's not good just to throw meds at people, we've got to do that, but we've gotten away from that. So, that's my comment. Thank you.

CO-CHAIR BAGLEY: Thank you, Connie.

Amy, you were next.

MEMBER MOYER: Recognizing that we're in an area I know very little about, I was looking at some work the Bree Collaborative had done in Washington State around opioids and they had also looked at 120 milligrams. And what they had included -- and I think I may have just heard this in the previous comment, was if you're going to go above that, there needs to be a consult with a pain management specialist. So I don't know, given that we're way outside my area, if that is something that works in clinical practice where it would be useful for this measure.

CO-CHAIR BAGLEY: Peter, you were next.

DR. BRISS: I just wanted to make sure that we're clear when we're talking about this measure that this is talking about chronic opioid use. And so it's not about opioids for things like post-op pain. And we should just be -- it's not acute pain, it's greater than 90 days. And so we should just be clear about what we're actually talking about.

CO-CHAIR BAGLEY: Good point. Winfred?

DR. WU: Yes, just one question or concern just around attribution. And in thinking about if this is a measurement over the course of a year, a provider who may be prescribing opioids on a short-term course and then this individual later seeking care somewhere else and meeting this definition, I'm just curious as far as how we'll be able to control for this. I mean, because based upon just reading the numerator and denominator, I could -- you know, it could, I think, easily be interpreted both ways, where either someone's being allocated to the provider that's writing the prescription versus just globally looking at the individual's claims over the course of a year. And if you had rendered care and you wrote at least one of those scripts, boom, you're dinged for that.

CO-CHAIR BAGLEY: Cindy and then Beth.

MEMBER PELLEGRINI: Yes. This is -- so I'm coming back in some ways to the comments that I made on the population-based measures, where

this is incredibly important data, there's no doubt about that, I'm just not sure if this belongs in MIPS, where the clear message to providers will be, your rates should be very low, right? And that may not be appropriate for certain providers.

CO-CHAIR BAGLEY: Beth?

MEMBER AVERBECK: So, I'm making a couple of comments on the measure specifications given that the steward is Centers for Medicare and Medicaid. But I wonder when we look at both numerator and denominator, it looks like one says 90 days and one says 15 days. So just in kind of the post-op for some of the orthopaedic procedures, you might see some prescribing in TCUs for a while that are going to see 15 days. Another suggestion might be, consider some of the end-stage renal failures in an exclusion. And then, if there was a measure in Washington, is there an opportunity to take a look at what those measure specifications are so we could maybe consider some alignment from the beginning,

because it's a very important topic, I agree.

CO-CHAIR BAGLEY: Okay. Did you have a response to that?

MEMBER MOYER: I was just going to clarify, the Washington is a guideline, I don't know that they have a companion measure.

MS. AUTREY: So, based on the number of comments that we've received prior to it coming to the MAP and the discussion here today, we still think that it is a very important measure that we would want to include and we know that there's a lot of work that needs to be done based on the discussion. So, very much important work and we appreciate all of the comments.

CO-CHAIR BAGLEY: I guess that would be kind of my summary as well, that everybody thinks this is very important, it certainly needs to be looked at very carefully in regard to the unintended consequences. I think that's probably the most compelling thing that we're asking you to take a look at because there's a lot of potential there. Are we ready for a vote? Okay.

Let's go ahead and vote on MUC15-1169, Potential Opioid Overuse.

MS. CHAVEZ: And the voting options are 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient Information. The voting is open. And the voting results for MUC15-1169 for MIPS are 95 percent Encourage for Continued Development, five percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR BAGLEY: Okay, thank you. Let's move on. Maybe we can do this before lunch, number seven, and I think, Stephanie, I think you pulled that one. You want to talk about it first?

MEMBER GLIER: Sure. I pulled both of the audiology measures. As Reva mentioned, it's great to see measures for the audiologists coming in, really happy to see that they're thinking about how to participate more in these programs and I would encourage them to try again. I think these measures are a good starting place, but

they really are documentation measures and, at the very least, if you're going to do a standardized test, maybe report the results of the standardized test so we can see -- get some data about what's happening, even if we're not setting a threshold of what the results should be, because obviously you're just trying to figure out how your patients are doing. But the documentation itself is insufficient information to show high quality care.

CO-CHAIR BAGLEY: So you're okay if we talk about both of these together?

MEMBER GLIER: I am, yes.

CO-CHAIR BAGLEY: Okay. Because they're the same issues, right? Yes. Go ahead.

MEMBER PELLEGRINI: As a discussant, when I was looking at these, I had that reaction as well. And also the fact that this is a really low bar measure, right? I mean, you're already at the audiologist, there's something wrong. If they're not doing functional assessments, what are they starting with? So, I'd like to

encourage them to go back and be a little bit more ambitious.

CO-CHAIR BAGLEY: I had a question for CMS, I guess. So, my understanding is that that visit to the audiologist would not be paid for by CMS. Now, is it okay to have a measure in Medicare where it's not reimbursed? Is that a problem for anybody?

MEMBER GLIER: It will be later. Audiologists are one of the list of providers who can be eligible professionals starting in 2019.

CO-CHAIR BAGLEY: I'm talking about the visit, not the bonus.

MEMBER GLIER: Oh, I --

CO-CHAIR BAGLEY: The visit -- is that -- it is covered? So this kind of assessment would be --

MS. AUTREY: I don't know about coverage.

(Laughter.)

CO-CHAIR BAGLEY: Anybody happen to know that offhand? Because it was my impression

that that was not part of the usual service.

MEMBER PACALA: So you're asking if the objective measure of a functional hearing status and functional communication, assessment of that, whether those are already included in a standard audiologic evaluation? Is that your question?

CO-CHAIR BAGLEY: No, my question was, if I'm a Medicare patient, which I am --

MEMBER PACALA: Yes.

CO-CHAIR BAGLEY: -- and I went to the audiologist, would it be covered by Medicare? I know it's covered by Medicare Advantage often, but would it be covered by Medicare? I think there's a question about that. They clearly don't pay for hearing aids, so --

MEMBER PACALA: Oh, no, they cover audiology. They cover --

CO-CHAIR BAGLEY: So that's not an issue?

MEMBER PACALA: That is not an issue.

CO-CHAIR BAGLEY: Okay.

MEMBER PACALA: That I can tell you for

sure.

CO-CHAIR BAGLEY: Okay, good.

MEMBER PACALA: I think a related question is, can they up-code if they do these things? And is there some kind of -- I don't know. This is my --

CO-CHAIR BAGLEY: I'm with you --

MEMBER PACALA: -- I'm standing on the grassy knoll here and --

CO-CHAIR BAGLEY: Right.

(Laughter.)

MEMBER PACALA: -- conspiracy theory. So I don't know whether that's the case or not.

CO-CHAIR BAGLEY: The comments -- go ahead, Scott, you're next.

MEMBER FURNEY: I agree, the documentation standards are relatively weak. And as we had a very involved discussion about improving depression to remission, it would be nice to have a post-evaluation, what is the patient's hearing after the intervention? So I think an initial measure at least of what their

results are as they do their assessment, but ultimately we would gauge the quality of their care based on the patient's impact of their interventions.

CO-CHAIR BAGLEY: Now you're in the -- back to my question, since the intervention's not paid for by Medicare, is it fair to judge them on that? And this isn't a payment discussion. Let's see, Stephanie, you were next.

MEMBER GLIER: I just wanted to put a little bit of a finer point on my comments, which is I think we'd love to see more measures from the audiologists, I think something like a functional status assessment over time would be really valuable. I would recommend not supporting continued development of these measures as they stand for the purposes of voting today.

CO-CHAIR BAGLEY: Beth, you were next.

MEMBER AVERBECK: So, I think, Bruce, to take your comment about even if it's not covered, if patients are having to pay out of pocket for hearing aids, that might be a really

important meaningful measure to have a functional improvement of hearing after an intervention. And, so even though it's not covered, it might be of value as the measure would go under further development.

CO-CHAIR BAGLEY: Excellent point. Yes, Gayle?

MEMBER LEE: I was just going to add too about going back to the even if it's not covered, some measures -- for example, I think maybe the BMI measure talks about referring to other providers and it's possible that their services may be covered, so maybe if the patient ends up with a speech-language pathologist or somebody else, it's possible that it may be a covered service depending on what it is. So maybe some piece of the measure talking about, okay, you did this test and then what's your next steps? Are you referring to another provider for follow-up care? Or something like that.

CO-CHAIR BAGLEY: Okay. Are we ready to vote? Or, Jim, you had another comment?

MEMBER PACALA: We're not talking about actual therapeutics here, we're talking about assessment, right? When you order a hearing evaluation to an audiologist? Am I right about that?

CO-CHAIR BAGLEY: The first one is actually a speech discrimination test, but it is an assessment, yes.

MEMBER PACALA: Well, speech discrimination should be part of a standard audiologic evaluation of -- particularly in an older adult, because that's also impaired. It's not just that they can't hear, they also have varying degrees of speech discrimination problems irregardless of the decibel level at which they can hear. So that should be a standard part. So that's a good idea. But this is all about assessment, right? Okay.

CO-CHAIR BAGLEY: Go ahead, Rachel.

MEMBER GROB: I just wanted to make sure that the discussion captures specifically the point, not only that we encourage the

audiologists to continue -- I agree entirely that these kind of measures are not where we want to go, but I want to applaud their attempt to gather information directly from patients and be very clear that the feedback we're giving includes saying, we want a patient-reported outcome measure. They should go in the PROM direction, because those are very valuable to patients.

CO-CHAIR BAGLEY: Other comments? If I don't see any hands, we'll go to a vote. Okay. I think we're ready to vote. And let's take them one at a time. The first one is MUC15-307, that's objective measure for functional hearing status.

MS. CHAVEZ: And the voting options are 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient Information. Voting is open. And the voting results for MUC15-307 for MIPS are 29 percent Encourage for Continued Development, 71 percent Do Not Encourage Further Consideration, zero Insufficient Information.

CO-CHAIR BAGLEY: Okay. Now, I'd like to go on to number eight, which would be MUC15-313.

MS. CHAVEZ: Okay. And we have the same voting options, 1 Encourage for Continued Development, 2 Do Not Encourage Further Consideration, 3 Insufficient Information. Voting is open. And the voting results for MUC15-313 for MIPS are 21 percent Encourage for Continued Development, 67 percent Do Not Encourage Further Consideration, five percent Insufficient Information.

CO-CHAIR BAGLEY: Okay. Thank you very much. That's so efficient, that's great. Okay. Let's go on to number nine, Ischemic Vascular Disease All or None Outcome Measure. Of course, we had some conversation about this earlier. So let's open up the discussion, maybe, Reva, do you want to just kind of give us the context?

DR. WINKLER: Sure. This measure I think we talked about yesterday for the MSSP is an all or none composite measure. I think the

context that I want to be sure everyone's aware of is, there has been in PQRS for several years a really very similar measure, the optimal vascular care measure, NQF Number 76, but in this year's PFS rule, it was removed. And the rationale provided in the rule -- and Sophia can perhaps expand upon that, but the rationale provided in the rule was that it was duplicative of the individual measures for Million Hearts. So that was the rationale given in the final rule. So, essentially, there was already a measure like this, if they've removed it, putting another one back in isn't -- I'd wonder whether that really made sense.

CO-CHAIR BAGLEY: Sophia, do you want to expand on that at all?

MS. AUTREY: So, you are right, we did remove it from the measure list starting 2016 because it was duplicative of the individual measures. But I think that this measure actually includes the piece that -- if I'm not mistaken, it does include the statin piece that was not

included in the older measure. Is that correct?

CO-CHAIR BAGLEY: Beth, go ahead.

MEMBER AVERBECK: Yes, so the Measure 0076 is going to come back, I think, in April. So the statin use will be part of it. I mean, it was taken off while we revised the measure based on the updated guidelines. I would say -- so it will be back and it is very -- I mean, I don't know the specifications of this one, but it's the same components.

MS. AUTREY: And so, because of that, the removal of the measure -- well, the removal of one of the LDL component was one piece of why it wasn't really something that we could continue to have in the program, but then, once that statin piece was added back in, we wanted to include it back into the measure set.

CO-CHAIR BAGLEY: Other discussion? All talked out about this the other day, yesterday? Go ahead, Stephanie.

MEMBER GLIER: Yes, I can just put the summary of our conversation yesterday, I think as

long as there is a measure of optimal care here, it would be great to have a composite. I don't want to be duplicative with the Million Hearts measures, but I think the composite itself has value. So, my recommendation would be, I'm not sure if this is the right way to vote or not given the voting options and the fact that we're talking about a measure that is not actually listed on the screen, but conditional support for a measure that follows the current guidelines that is a composite measure of optimal care.

MEMBER MOYER: And, further, given that there is the endorsed measure and the endorsed measure coming back, I would fully support that being used in the program, but it feels really odd to then go with this other measure that hasn't been through the process, but is kind of the same.

DR. WINKLER: In terms of this measure through the NQF process, it was submitted to us and its evaluation final disposition is deferred until it can be put head-to-head with the

Minnesota measure in the spring, because there are minor differences, but they are essentially very, very similar.

CO-CHAIR BAGLEY: Peter?

DR. BRISS: I do want to say that HHS has, to its credit, I think has gone through a lot of effort to align cardiovascular measures. And so when we started out five years ago, there were 30-some different measures in active use in HHS programs just on hypertension. And so there's always a reason for more measures of the same stuff and it's always arguable about which one's the best one, but I'm not personally convinced that more measure creep is actually what we need. Actually I think that going from 30-some hypertension measures to one is a pretty good achievement and I'm not dying to do that again.

CO-CHAIR BAGLEY: Not sure what you're recommending here, Peter.

DR. BRISS: So I'm not personally convinced that we need more measures that

duplicate the existing Million Hearts measures.

CO-CHAIR BAGLEY: Beth?

MEMBER AVERBECK: So, is the Million Hearts measure -- I'm just not familiar with it, is it a bundled all or none measure? Separate components?

DR. BRISS: There are four separate measures on the four topics. The choice comes down to how strongly you feel about an all or none composite versus how strongly you feel about parsimony probably.

CO-CHAIR BAGLEY: Everybody's tired and hungry, is that what the problem is? Amy, go ahead.

MEMBER MOYER: So I'll throw out, I think the advantage of this over those individual measures, particularly when you're looking at Physician Compare, is looking at it as a patient, you're not in a position of saying, well, if I go there, they're doing a really good job with blood pressure, but if I go there, they're doing a really good job with statin. You can pick based

on who's going to do the best job of getting you all of those components of your care that are important. It's much easier to use.

CO-CHAIR BAGLEY: I guess -- oh, go ahead, Beth.

MEMBER AVERBECK: Just a question, so on this either support or conditional support, are we supporting an optimal vascular measure yet to be determined which one through NQF or specific to this one?

DR. WINKLER: You have to -- the recommendation has to be specific to this one, that's the job.

MEMBER GLIER: So, my personal recommendation, which you are welcome to dismiss if you would like, is to conditionally support this measure pending the NQF Committee's side-by--side review of this measure against 0076 when 0076 is done being updated with the guidelines, with the intention of telling CMS that I would like to see an optimal vascular care measure in the MIPS program. I don't have a dog in this

fight.

CO-CHAIR BAGLEY: Robert?

MEMBER KRUGHOFF: So, in general, when we conditionally support, is it still something that CMS can go ahead with this year or does that require another cycle through?

CO-CHAIR BAGLEY: Do you want to answer that, Sophia?

MS. AUTREY: If it's conditionally supported and once it goes through the process there are significant changes, it would still have to come back.

MEMBER KRUGHOFF: It would have -- so it puts it off for a whole year?

MS. AUTREY: Yes, if there are significant changes.

CO-CHAIR BAGLEY: If there are significant changes, of course, however you want to define that, but, okay.

MS. AUTREY: If there are not significant changes, then it wouldn't have to come back.

MEMBER GLIER: So for this measure, if we conditionally support it with the condition I just suggested about doing a side-by-side and it goes to a side-by-side and the NQF committee says 0076 is the winner of these two, I assume that because you're already using 0076, you could use it again. But if this measure is the winner of the side-by-side, then our conditional support, assuming it doesn't get changed in that review again, would mean that CMS could use it in next year's rules. So, CMS would not have to come back to us if the measure meets the condition that we specify.

CO-CHAIR BAGLEY: So that makes that very important. Maybe -- let me try first and then we have to make sure that NQF agrees with this, but I'm hearing you say the conditions are to reevaluate the statin part of it based on the new guidelines and make sure that that's part of it, and also to consider having it be a composite all or none measure. Are those the two things? No? Okay. Please --

MEMBER GLIER: So the condition for this measure, which is the Wisconsin -- the WCHQ Ischemic Vascular Disease All or None Outcome Measure, which already has the statin component in it, the condition would be that it meets current guidelines at the time that CMS is considering using it, which CMS would do whether we said that was a condition or not, and that the NQF committee reviewing the vascular care measures has had the opportunity to do a side-by-side comparison of this measure that we're voting on with 0076, that we're not voting on, and has chosen the best of the two measures, since they are very similar.

CO-CHAIR BAGLEY: I want to -- I mean, you're the one that has to write this down.

DR. WINKLER: Right. Well, essentially, that's already planned and will happen next spring. That's exactly what's -- and we're already ready to be doing that. So if you're saying that it's conditional on the result of that evaluation, then that's fairly

straightforward.

MR. LYZENGA: Would a condition also -- I just want to clarify what I'm hearing, of approving an all or none composite for this program be that the individual Million Hearts measures be removed? No.

DR. WINKLER: No.

MR. LYZENGA: Okay.

CO-CHAIR BAGLEY: Are we ready for a vote? I see heads nodding, so let's give it a try. So we're going to vote on MUC15-275, and since this is an NQF approved measure, it's --

DR. WINKLER: This is not an NQF endorsed --

CO-CHAIR BAGLEY: -- a fully developed measure.

DR. WINKLER: -- it's a fully developed measure.

CO-CHAIR BAGLEY: Thank you. Minor slip on my part. Support, conditional support, do not support.

MS. CHAVEZ: Thank you. Voting is

open, 1 Support, 2 Conditional Support, 3 Do Not Support. And the voting results for MUC15-275 for MIPS are five percent Support, 81 percent Conditional Support, 14 percent Do Not Support. So the vote for this measure is conditional support.

CO-CHAIR BAGLEY: Winfred?

DR. WU: So this is clearly a different vote than yesterday's MSSP vote and so, I mean, can we revisit that original recommendation that we submitted yesterday? Clearly, since we have a different -- I don't see the difference in opinion as far as why we would favor this for MIPS and oppose it for MSSP, but maybe we can first put that up for a conversation?

CO-CHAIR BAGLEY: I would entertain a motion to reconsider.

MEMBER NIELSEN: I second the motion.

CO-CHAIR BAGLEY: Somebody has to say it first. Winfred, let's assume that you made a motion --

DR. WU: Yes, motion to move to

reconsider.

CO-CHAIR BAGLEY: Thank you. Okay. And a second, thank you, Marci. Okay. So, I'm not sure how we're going to do this voting wise, but basically, we have to revote as if we're considering MSSP. Are you okay with that, Reva?

DR. WINKLER: I don't have a problem with it because one of the major issues that the Coordinating Committee really wanted you guys to focus on was alignment, and so you just did it. And we now can talk about how good you did it by bringing it up and revisiting. So, yay.

CO-CHAIR BAGLEY: Just to review, our recommendation yesterday was --

DR. WINKLER: Yesterday, the vote was ten percent Support, 40 percent Conditional Support, so the sum is only 50 percent on the support side, and then 50 percent Do Not Support, which lands it in the do not support category. The question is, are there real differences between the two programs that you want to think about for this measure? It's perfectly fine if

there is a difference in your recommendation, as long as we understand what it is, and typically based on program characteristics.

CO-CHAIR BAGLEY: Beth, you had your hand up.

MEMBER AVERBECK: Well, I think part of the confusion yesterday might be given that there's already an existing measure that's going to be reviewed and then this is a duplication. So I think the conversation today, we had more clarity around what it was we were voting for and so that might be part of the difference.

CO-CHAIR BAGLEY: Everybody comfortable with this? If you're not, this is the time to speak out. Please, go ahead.

DR. ALEMU: I just want to point out that the statin use measure, it has to be clarified whether it speaks to the 2013 guidelines. This was, I think, before that. But if it speaks to that one, that's fine.

DR. WINKLER: This measure does. I mean, that's the whole thing that's going on,

that's why there is some of this.

CO-CHAIR BAGLEY: Scott?

MEMBER FRIEDMAN: So, I'm a simplistic person here, again, a newbie. So what I'm hearing is that there's a measure out there that is similar to this measure, maybe the exact same, and we don't want to have -- we don't need to have two measures that do exactly the same thing. So, I mean, maybe it's semantics that we vote one way yesterday and a different way today because we're saying the same thing and the votes are somewhat nebulous at best -- at worst, and who knows. So, what I'm hearing is that we have a measure, this measure is good, we want to have a measure like this, but if we have two measures that are the same, we don't need two measures. And maybe the vote doesn't really mean anything because it's all been discussed anyways.

CO-CHAIR BAGLEY: Rachel, I saw your hand first, then Peter.

MEMBER GROB: Yes. I mean, I think what we're saying is, we only need one measure.

What I hope we're saying is we only need one measure in MIPS, we only need one measure in MSSP, and we trust NQF to do the side-by-side analysis and decide which measure it is and implement with just one measure for both of the programs.

CO-CHAIR BAGLEY: Peter?

DR. BRISS: And so the last comment I would make is that in this subject matter, I wonder whether there's such a great rationale for an all or none composite in terms of driving improvement or being interpretable. Because the performance on all four of the components is relatively low. So say it was 50 percent on all four components, which is not so far away from real life, that means that where you'd be on an all or none composite is approaching zero, right? And so, it's not so clear to me -- it would be different if performance were higher.

CO-CHAIR BAGLEY: It's in the single digits, but not zero. Go ahead. Beth, go ahead.

MEMBER AVERBECK: Just to -- an optimal

measure before the statin use was around 60ish percent in a number of systems for the all or none for vascular. So, I mean, there's variety and that's where the opportunity was, but yeah.

CO-CHAIR BAGLEY: Scott?

MEMBER FRIEDMAN: So, again, that was your interesting comment yesterday is that the composite results are going to be very low and docs don't want to be really low, they want to be really high. And I don't necessarily disagree with that. But there's some people in the room that are saying composite measures are really good and then some people in the room are saying composite measures aren't really good. And, so, maybe we should have a little bit more discussion about whether we should have composite measures or just four individual measures for this. I think overall that health is important and these are all measures that trying to save disease and trying to prevent cardiovascular disease, and the question is whether we should be measuring at the same time or individually?

CO-CHAIR BAGLEY: David?

MEMBER SEIDENWURM: Well, so, the first point I'd like to make, I think is that in a lot of these areas, the components don't sort independently. So you don't get to six percent, you get to 38 percent or something -- making up the number, because there are some sites that are doing all four things or three of the four things really -- you know, they're doing four of the four things, and other sites that are doing none of them. So I think that that's one point to bear in mind that I don't think it comes down to five percent, even though that's what the simple arithmetic would show you.

The other thing is, I think that what I'd like to know in terms of the biology of this phenomenon, is there a synergistic effect among the different components? We know that doing each of them independently improves health, but what I'd like to know is, does doing all four of them at once, is that more improvement in health than the sum of the individual components? And

then the other question I'd like to ask is, if the participation in the program is voluntary, are people just going to pick one metric and satisfy their obligation, or -- in which case we need a composite. Or if the participation is mandatory and they have to participate in all four and are judged on all four, then the arguments in favor of the separate measures I think have great merit. So, I guess I have those questions that I'd like to ask.

CO-CHAIR BAGLEY: Winfred?

DR. WU: So, I think those are all great points. And I think the other thing to focus here on is the fact that the composite measure focuses on ischemic vascular disease, which we know is -- comprises a group that's going to be at the highest risk for a repeat event, whereas when we look at the individual component measures, the one focusing on hypertension includes not only those who have potentially IVD, but, again, folks who have just central hypertension, maybe no other major

cardiovascular disease factors. The same thing with the statin measure, which is a three component measure. So the IVD component is just one of a larger group of individuals in that population. So I think that speaks to the importance of having a composite measure that focuses on this particularly high risk group.

CO-CHAIR BAGLEY: Scott?

MEMBER FURNEY: The composite measure I think is the better one to drive improvement in all measures. And that may seem somewhat self-apparent. In this particular measure, it's somewhat unique in that the lagging measure will always be the tobacco-free component. That's the one that's, I think, the least under the influence of physicians, the most recalcitrant of the conditions, but we use composites for the majority of our metrics when we have them developed and they mature from individual into composite, but it makes you think about your quality improvement very, very differently.

And I think the risk of having

individual measures, as was said, is that the one measure that will be the most difficult to move, the laggard, in tobacco use, will be the least addressed. And we know that that is actually the most important to address and to resolve. So I think that that's one huge benefit of using the composite. And here is the one measure that will really drive that composite is the one that is the hardest to move.

CO-CHAIR BAGLEY: Jim?

MEMBER PACALA: Scott said it.

CO-CHAIR BAGLEY: Yes, okay. Are we ready to vote? Okay. Now, we're going to vote on MUC15-275 in relation to the MSSP program.

MS. CHAVEZ: And the voting options are 1 Support, 2 Conditional Support, 3 Do Not Support. Voting is open. The slide did not show the results. Okay. Unfortunately, we'd have to revote.

CO-CHAIR BAGLEY: We're going to have to revote. So, are you ready to go for the revote?

MS. CHAVEZ: Yes, we are. And it's the same voting options, 1 Support, 2 Conditional Support, 3 Do Not Support. Voting is open. Okay. So the results for MUC15-275 for MSSP are five percent Support, 90 percent Conditional Support, five percent Do Not Support. So the recommendation is conditional support.

DR. WINKLER: And the condition is as Stephanie specified.

CO-CHAIR BAGLEY: Consistent across programs, right?

DR. WINKLER: Right, we're being consistent.

CO-CHAIR BAGLEY: Well, we're at --

DR. WINKLER: Aligned.

CO-CHAIR BAGLEY: We're at an important juncture here. I think that we've made great progress and had very good conversation and I don't think anybody's felt that they haven't had a chance to talk. So we're making pretty good progress. We have lunch scheduled and we have a couple of important open discussions after lunch.

I would prefer not to predict what time we might be finished, but it looks like we'll clearly be finished before 4:00.

So I guess I need to hear some from the group about should we have a relatively short lunch and keep on going and hopefully make some earlier flights and stuff like that? I see a lot of head shaking. So, 15 minutes to get your lunch and we'll start at 12:30. Do you want to try that? Is everybody okay with that? I see general agreement, we don't have to vote on that.

(Whereupon, the above-entitled matter went off the record at 12:16 p.m. and resumed at 12:40 p.m.)

CO-CHAIR WHITACRE: In the interest of time, I thought we could go forward, especially as it's a bit more of an open-ended discussion.

We're at the point where we'd like to discuss gaps and this is specifically gaps in the clinician program measures set.

When I looked at this, I wanted to tack on some other ideas of perhaps process

improvement and so forth that we can get to later.

But, if we could spend some time -- and I know Reva has a presentation on this, addressing specifically the issue of gaps in the measure set for clinicians.

DR. WINKLER: I wanted to spend some time talking about a couple of the topics that the Coordinating Committee focused on in their in-person meeting in September.

As you know, the Coordinating Committee has the role of overseeing all the MAP work across the four different committees.

And so, the two particular topics I'd like to talk further with you about were gaps and the other one is alignment.

So, gaps is one of those traditions that, at the end of every sort of meeting, we sit down and talk about gaps. But, what's happened over the course of time is we've ended up with a very long list of gaps and that's it. It's a very long list of things, everybody's favorite

topic sort of tossed onto the pile.

And so, I think -- and one thing the Coordinating Committee would like to do is to begin really thinking more strategically and maybe systematically about gaps as opposed to just, you know, make a list and isn't it fun?

So, I mean, something to think about for the clinician measures, and I haven't included the MSSP, I'm really looking at the clinician measure set that's currently, you know, used for PQRS. Those measures are the source of many measures that will evolve into MIPS.

You know, there are about 300 measures on the list already. We just looked at another 58 measures. It's a big group of measures.

And so, one thing I would love to hear some suggestions as opposed to just, you know, tossing out the ideas to add to the laundry list, is can you think of a way of potentially -- some way more strategic to think about gaps in the clinician measure set?

You know, one of the things I noticed

even on the laundry list is there were often topic areas that would be raised. But then, there were also types of measures or types of things to be measured that were offered that, perhaps, might apply more globally or crosscutting that could be useful.

So, you know, as we're thinking about gaps, this is an evolving type of idea.

One of the things the Coordinating Committee in their January in-person meeting is going to be doing is looking at trying to develop a way -- framework if you will, I don't know, core concepts, if you will, taking all that's going on in all those areas out there.

We're not creating a new one, but look at all the various things that are out there and how we might use them to better understand how, you know, where are truly the gaps that need focused, you know, measure development or, perhaps, what Chris Cassel calls measure mining, going out and finding, are people out there somewhere that we're not familiar with at this

point in time, you know, doing and using measures in those -- in that way.

And so, during the course of your conversation over the last two days, you have talked about some global type gaps, both in types of measures as well as other things.

But, before we get started, I just wanted to sort of give you an update.

Last year, the -- sorry -- the gaps list was as you see it. It tended to be the more laundry listoid sort of thing. And, I just wanted to show you where the MUC list from this year kind of addressed things.

And so, I think there are still some areas that are potentially a gap. But, I would, again, would like to notice that if you go down to -- down the list down to trauma care and geriatrics and fragility, you can kind of draw a line.

And then, there are other types of measures that look at the set differently around things, diagnostic accuracy. I know, Bruce, you

had mentioned diagnostic efficiency at one point. So, that's something that's not condition-based but may be a type of approach to looking at quality that may be a little bit different.

What we saw over the last two days is meeting the gaps in a measures or specialties with few measures. I mean, that's pretty much what we've done.

And then, measures for EHRs that promote interoperability.

There were really only, I think, three e-measures within the set of measures we saw despite it being an identified need and goal for CMS.

So, in terms -- so I'd, you know, really like to hear some thoughts about it. Kate, did you have anything specific in terms of gaps that would be -- how would -- can the MAP particularly assist and provide, you know, meaningful feedback to CMS on this subject?

DR. GOODRICH: So, part of the reason you haven't seen a lot of these gaps over the

years filled is probably because there's a dispersion across a number of developers developing measures for the clinician setting.

We actually have developed very few measures for the clinician setting historically. You know, because that's really been done by others.

And so, when you have that many people developing measures, there's not necessarily a unified approach.

Now, we have an opportunity here to make some inroads on this or whatever other list or expanded list we come up with in part because we will be starting to develop measures as required under MACRA.

So, I think, you know, I feel like when we talk about gaps, we often but not always come up with at least some very similar themes in terms of types of measures and even areas like geriatrics and frailty and diagnostic accuracy, which, by the way, is really tough. But, we think we're working on.

I think what would be helpful for us is not only, you know, continuing to think about where there are key areas where there's no measures or very few, but prioritization, because that's going to be I think the big thing that we're going to be challenged with once we start developing measures. It's how do we prioritize?

It's actually not a huge amount of money. It may sound like it is, but it's actually not. And, we also feel -- are sort of debating internally with, you know, how much do we put into what I'll sort of call the infrastructure for measures related to standardized and data elements and standards and that sort of thing in addition to developing actual measures. I don't know if folks have thoughts on that, but we'd welcome that.

So, for me, I feel like we sort of know the general types of measures that are needed, you know, it's what's in MACRA, it's what everybody's talked about here.

If there are additional areas beyond

what's on this slide, we want to hear that. But, for us, it would be really helpful to hear about prioritization. What is needed most fastest?

CO-CHAIR WHITACRE: I was daydreaming. David?

MEMBER SEIDENWURM: To get the ball rolling, I'm going to start with diagnostic accuracy because I can't help myself.

And, I think that there are ways that we can get at diagnostic accuracy indirectly. But, directly getting at diagnostic accuracy at this stage of the game I think is, you know, beyond our ability.

I mean, there's just been a, you know, an IOM report that -- and they pretty much threw up their hands and said, you know, we need more research and, you know, they said it better than that, but we do need more research.

But, in the meantime, we can get at a lot of the intermediate steps, I think, or at least some of the bigger problems in diagnostic accuracy in three or four different ways, you

know, if we had the proper encouragement I think.

One thing that we could look at, for example, was we could just have a metric of autopsy rate, you know, per whatever unit at the hospital and then, you know, that would ultimately get people thinking about diagnosis and it would encourage that.

So, maybe even some kind of hospital measure maybe or other type of population-based metric of autopsy rate, again, to be developed.

There are -- appropriate use measures are actually diagnostic accuracy measures. They're appropriate use of diagnostic procedures because, by enriching the prior probability of disease in the population, they make the predictive values of the outcomes of the test more usable, you know, and higher.

So, I think if we encourage appropriate use measures in diagnostic tests, and we've heard about endoscopy and, you know, other imaging tests and I'm assuming also laboratory tests, you know, that behave in the same way.

So, I think that we could improve diagnostic accuracy, you know, for our whole health care system in that way.

The other thing that we can do is by looking at bringing in metrics that exist in other areas of medical practice into these programs to emphasize their importance.

And, for example, in the hospital outpatient for perspective payment system, there's a mammography recall measure that's based on administrative data. It's, you know, it's about as well tested as a measure can be. I mean it's been in Hospital Compare now for I'll say five years, but it could be, you know, plus or minus. And so, we could bring that in.

And I think, in addition to that, if we could bring in other easily calculable for mammography metrics such as biopsy positive predictive value and invasive cancers per thousand and things like that, that would help us, you know, square the whole circle around the mammography guideline controversy because, you

know, the issue is what is the level of harms that we're doing, right?

And so, if we could measure those things, we could decrease the level of harms and, therefore, the controversy about the number of women getting mammograms would commence shortly, we would help diminish.

And then, another area that we can look at in imaging, and I think this would also have to do with other types of diagnostic procedures -- again, I'm going to use endoscopy as another example, would be the sort of incidental findings problem.

And, we've put forward a metrics in imaging incidental wellness, you know, imaging incidental findings that, you know, have not made it through the process for various reasons.

And, you know, I think if we encourage those things, then at least we would improve diagnostic accuracy, not necessarily by increasing sensitivity, but by increasing specificity, which is the other side of the

diagnostic coin.

Another area in which we could increase diagnostic accuracy was if we thought about kind of care families. And, I don't know how to say that exactly, but what I'm trying to say with that is, if we're saying that a certain procedure should be done, you know, be it a surgical procedure or a diagnostic procedure of some sort, then if we had metrics with respect to the quality of that procedure, then we would wind up with diagnostic accuracy in the sense of the procedures would be indicated to begin with and they'd be performed correctly.

So, I think if we thought that way -- and, let me give a specific example. And, I think it was proposed a couple of years ago in colonoscopy, you know, there were certain, you know, four or five metrics of colonoscopy quality, you know, withdrawal time, you know, how far do you get? You know, what's the interval between them? You know, what did you do with the specimens? And things like that.

That there must be analogous opportunities for all kinds of other care with respect to, you know, diabetes or, you know.

So, I think if we kind of thought about nests of measures, you know, that might be appropriate to the subspecialists along the way, that would then, you know, contribute to whatever this apex is, we might help in that whole sphere of things.

CO-CHAIR WHITACRE: Terrific, thank you.

Peter?

DR. BRISS: So, part of our problem is that -- so, I should have said in my disclosures yesterday that I'm a lumper not a splitter, right? So, I've now disclosed.

I think part of our problem is that that makes some of these gaps so hard to fill is that we're so hyper-specialized in the measures that get developed in part because the people that are developing measures are -- kind of start from a very specialty orientation. Right?

You know, so it strikes me that for many of these gaps on things like patient experience, shared decision making, care coordination, there might be -- you might be able to design a few measures that address a whole lot of quite different patients and providers.

And, we might be able to meet a lot of our needs sort of for parsimony, understandability, meeting the needs of multiple specialties. You know, there's all kinds of problems -- and I kind of said some of this yesterday, that there are all kinds of problems that could be, in principle, solved by having some -- seeing if there's some areas where we could get some general measures that applied across contexts.

And, the let a thousand flowers bloom bottom up structure of getting measures submitted doesn't help us with that very much. Maybe the incubator could help us with some of that stuff. Right?

And, to a lesser extent, some of that

could also be done in the more topical measures that I would encourage developers and committees to, whenever they see a measure, to think about, so what's the broadest denominator to which this measure could be put?

You know, so we had an experience lately with, I can't remember the details, but we saw a measure concept under development, but it was for some sort of -- some specialized subtype of dementia.

And, it was sort of how well are they thinking, right? You know, and so, it struck me that this might apply to essentially every dementia, perhaps, and maybe even a broader set of neurologic diseases. And, you might be able to address a whole lot of things at the same time.

I think we could do much more at broadening things than we're currently doing.

CO-CHAIR WHITACRE: Thank you.

Luther, Beth, and then Bruce.

DR. CLARK: One area that I think

might be a gap but may be included under shared decision making and that is really how do we better include patient values and preferences? And, not necessarily new measures, but which of the measures might either lend themselves to this or be impacted by considering what the patient values and preferences are?

And, I was thinking back in terms of some of the discussions around conservative versus invasive approaches, you know, in the life care where a patient preference might influence the decision, but we're measuring, you know, the clinician's performance.

So, if we look at the current measures, which of those might lend themselves to taking that into consideration?

CO-CHAIR WHITACRE: Thank you.

Beth?

MEMBER AVERBECK: As I look at the measures around prioritization, you know, as we're starting to see the costs of care go up again, I wonder if we want to put a lens on

around, you know, are the quality measures where we are, they're not perfect.

Are they good enough that they might be good enough to then say should we switch our efforts to either those -- and I'm a bundler too. So, is it around shared decision making across either existing measures or a shared decision making that could be applied to one?

And that I would put under patient experience because I don't know that it necessarily saves costs.

But, now we have choosing wisely and more comments around appropriateness. Is there an opportunity to take a look at some of those choosing wisely categories and are there measures that are being developed around those categories?

Are we even taking a look at preventative services? We've done a really nice job of measuring underuse, have we measured overuse? Pap intervals? When do you start? When do you stop? Colonoscopy intervals?

I mean there might be -- so, that's

maybe small dollars individually, but it's large volume and it's -- so, potentially looking at appropriateness might be an area.

CO-CHAIR BAGLEY: You know, this is probably going to sound like it's really off the wall, but I'm going to try to make a point in the end, so bear with me for a minute.

You know, in other places in our society, let's take publically traded companies, they're measured by some very specific outcome measures that everybody knows what they are. And, nobody tells them which process measures to use to get outcomes like profitability and market cap and, you know, EBITA and all that kind of stuff. That's just stuff that that's how we measure them. They're very clear outcomes for companies.

And, we don't go to those companies and say, well, you know, if you use these process measures, you'd do better on the stock market. We don't do that. We let them figure that out themselves.

So, my point is that, is there some way that we can foster participation in quality improvement that has some outcomes?

Now, here's where I'm going next, and the outcome ought to be health. You know, we're on a path to try to measure every little tiny piece of the medical industrial complex and make sure that we whip them into shape.

I think that, to some degree, is a fool's errand as was Peter's point, I think.

But, what about if we had a measure of health? So, let's think about an ACO getting a global payment to take care of a population of people. Or, for that matter, a community that's undertaken the health of their population, what measure might be most -- so, here's all or none composite for you. It's BMI, blood pressure under control, smoking, you know, some stuff that really would make a difference, you know, age appropriate screenings and immunizations.

And, sort of, you know, these are our at least intermediate outcome measures for

health. What a concept. I mean, I don't see that on this list anywhere.

So, I'm sorry, that's probably not what you're looking for, but sometimes, it's time to rethink how we're trying to accomplish what we're trying to accomplish. It's the old idea that if we keep pulling people out of the river without going up the river to try to find out why they're falling in. We're just pulling them out of the river, we're not finding out why they're falling in.

CO-CHAIR WHITACRE: That's great, thank you.

Amy, Jim, and then Robert.

MEMBER MOYER: I have a bunch of things to build on here.

In terms of priorities off the list, I think definitely, you know, patient-centered measures -- especially as I was looking through the cancer set, you know, we don't have a lot about functional status, symptom management, pain management, those kinds of things.

You know, patients are there throughout the whole process of care. It's potentially a really rich source of data that we're just not tapping as much as we could be.

I think appropriate use isn't necessarily specifically called out in there.

I'll also out myself as a lumper and part of that is as I think of, you know, we are working at transforming how we pay for health care. We pay providers and we're just on the start of a bundled payment journey.

And, to kind of do those things, the measures you need, you need a lumped, broader measure set. Really specific measures don't lend themselves well to that kind of application because you need to have a risk pool and a larger sum of patients.

And, I like your health measure. I kind of a have a five that I always talk to people about, you know, physical activity, healthy eating, don't drink too much, don't smoke. And, if we could do all those things

without stressing people out, that's my fifth, because that would be really good.

So, I think that's all of my points.

CO-CHAIR WHITACRE: Terrific.

Jim?

MEMBER PACALA: I know you've thought about this, but I would make a bid for better measures for care of the complex multimorbid patient.

And, I see in the MAP the idea of quality-based compensation and improvement going the way of guideline development. And, you know, we've developed all of these guidelines and the guidelines for all these different specialty societies, right, and they came up with very specific recommendations that, when you're taking care of a multimorbid or a frail patient are often inappropriate or often dangerous.

And so, you end up making a conscious decision as a team or a clinician to go against what you know is a guideline recommendation and you're doing it for a patient-centered overall

functional outcome purpose.

And so, I know now guidelines are starting to adjust, the whole idea of guideline development is trying to adjust for that.

So, I'd like to see quality do the same thing. And, you know, I think if we could figure out measures in which somehow a care team or a provider demonstrated that they made an appropriate patient-centered decision that was in concert with the patients' goals, so incorporating goal oriented care into it, and then a conscious decision to not follow a guideline.

Or establish an outcome that was of meaning or a goal that was of meaning.

So, for example, take diabetes, that there is evidence with different patients that the clinical team has settled upon and a glycemic goal for that patient that is consistent with their overall function, life expectancy and so forth.

And, you might say, if a patient -- if

a team came up with a glycemic goal of 8.5 percent for an A1c for a patient, that might be excellent care. That might be very, very good quality care. And, there might be other processes and care measures that go with that. And, that might also be consistent with what the patient wants.

Whereas, for another patient of the same age, a goal of 7.5 percent might be appropriate, depending on what their comorbidities are and functional status.

And that, I think that reflects higher quality care. So, I know people are working on that, but if you could somehow capture that type of thoughtful patient centered decision making that was looking at the combination of multimorbidities rather than looking independently at each morbidity in a multimorbid patient. Very hard to do but -- and I know people are working on it.

CO-CHAIR WHITACRE: Thank you.

Robert and then Stephanie and then

Cindy?

MEMBER KRUGHOFF: I think this is wonderful, everything I'm hearing and quite ambitious, but I think we're talking about the things that need to be done.

I'm going to be a little more -- even more remote from reality here, I think, in the sense that MIPS wants to do something or wants help with us to do things they can measure, you know, this year or next year, four years from now.

I'd like to think of our role as a map for clinicians to also be thinking how can we create the kinds of databases that are necessary to do a vastly broader range of much more meaningful measures?

And, maybe I'm picking up on what you were saying also, Bruce, that, you know, it's the overall system.

And so, you know, it's obvious to me that the limitations of the -- of what's coming out of the EHR, the Meaningful Use expansion.

Okay? And, I think it's wonderful that we're moving, you know, forward with the EHRs but the -- it's just very slow that we're moving toward having massive pooled databases of real clinical information.

And, beyond that, even more frustrating that, you know, getting to the point where that's -- those data are actually analyzable, you know, by the Feds if they want to do it or by anybody else who wants to do it and reportable at the individual doctor level or even the practice level, depending on what the appropriate level is.

You know, that kind of, you know, moving down that path. I just think we have to shout out to CMS, yes, it's good that you've gone where you've gone with electronic, Meaningful Use, but this is a massive new change that has to be made if we really want to encourage quality, be able to measure quality and be able to measure it so that we're not even -- we're not picking around the immediate possible measures, we're

thinking --

I mean, there are thousands of measures that could be used for particular situations if you have those EHR data.

And, I just think we should -- we need to shout that out, you know, constantly. I think, you know, there are some sort of in between stages where we could have, you know, where hospitals could be more responsible for picking up on lab and imaging data to go along with their claims data.

And, if you had those things, you could do quite a bit of analysis that would be more meaningful in terms of quality both of hospitals and of the doctors who are practicing in those hospitals. So, I think moving forward on that, it is possible.

And, as those of you who've been on this -- put up with me on this committee for all these years know, I'm very frustrated on the front of patient experience because I think we know how to do it.

And as some of you know, you know, my organization, what, eight years ago or so, demonstrated that it's not that expensive to do. I mean, it's, you know, $120.00 a doctor or something to have really good patient experience results.

And, the fact that CMS has not pushed forward on that so that includes, you know, that could include shared decision making, care and coordination. It can include communication, all those are things that are very important to know about doctors, and have clear relationships to outcomes.

And, CMS is just -- just hasn't picked up on this. They could do it, it's very doable. I mean it would cost, you know, millions of dollars, but tiny next to some of these other things that we're talking about. So, that, I think, is very frustrating.

And then, I think patient reported outcomes, it's a much more problematic thing to get people to, you know, everybody to respond on

what their conditions were and what their outcomes were, et cetera. But, I think that would be a very good thing.

You know, I remember years ago I was on some IOM committee and the suggestion was, we should require patients every year when they want to renew their health insurance to fill out, you know, some sort of health status measure and functional status measure, et cetera so we just have this on an ongoing basis.

At any rate, all these things have to do with building the information infrastructure that takes us beyond the point of picking up on the particular measures, many of which are process measures or intermediate outcome measures, to actually having measures that really get to the final thing that we want, you know, that those corporations are trying to achieve.

CO-CHAIR WHITACRE: Stephanie and then Cindy?

MEMBER GLIER: Thanks.

I think I'm mostly building on what

other folks have said, so bear with me a little bit.

I think in terms of prioritizing for a case request for some input on priorities, I agree with Robert wholeheartedly that I think we need to -- I would very much like to see CMS invest some money from the MACRA measure development stream in the data infrastructure.

We need to do a better measurement pipeline overall so that there's faster, easier measure development and we're not relying on slow processes to the -- at least as we are now.

I, unfortunately, don't have a whole lot of like really brilliant insights about what that looks like, so happy to --

CO-CHAIR BAGLEY: It's called Meaningful Use. I'm sorry.

MEMBER GLIER: I'm not touching that one.

Health related quality of life, I think there is a lot to be said for health related quality of life tools. I think building

them into functional status and patient reported outcomes would be really valuable so that we're not only looking at what is your function specific to this individual condition but also how are you doing more generally.

So, if there are measures we can build out of PROMISE or other tools that do that sort of general how is your health work, I think that would add a lot to the sort of patient experience tools we have now with CAHPS where it's about your experience intersecting with the health care system.

But, we also need to know how you are doing on your own in your life where you exist most of the time as a patient.

And, similarly, and I think this actually builds a little bit on what Jim was saying earlier, I certainly empathize with the specialties who don't feel like they have enough measures to report or they have no measures to report.

But, I would really encourage CMS not

to take that bullet point that's listed on the gaps from last year as a current priority. I'd rather reframe it as thinking about patients who need care and what good care looks like for them.

So, I think this reflects back on the conversations we had yesterday when we were looking at the dermatology measure for organ transplant patients. Important thing, we want them to get screened, but there is probably a whole list of good practice care for organ transplant patients who, all of those things should be met regardless of which practitioner you are seeing.

And I think there's some work to be done making sure that those providers can work together to come up with the right measure and we can do the right attribution of things.

But the patient centeredness of that needs to be focused on what does good care look like for a patient? How can we help people be as healthy as possible? And, how can we use the resources in the system to the best effect?

CO-CHAIR WHITACRE: Thank you.

Cindy and then Mady?

MEMBER PELLEGRINI: So, I'd like to put in a big plug for care coordination. But, not just among providers, really starting to think about care coordination out into the community and out into all different other parts of, not just the health care system, but all the other kinds of supports and services that a lot of people need.

And, I won't take too long, but I want to commend to folks two articles or pieces that appeared in the media in the last week that I think crystallize this argument more than anything else I could ever say.

The first was The Washington Post on Sunday had a front page article about the 16-year-old who was the youngest survivor of the shooting at the community college in Oregon about six months ago.

So, she got state of the art medical care as a victim, weeks in the hospital, et

cetera. But then, I pulled it up here, because then she got sent home, it says here, to a flea-infested rental home with reinforced locks, curtains darkening the living room where she sleeps because, you know, she can't sleep in a regular bed due to her injuries right now, on a $5.00 garage sale recliner that her mother bought.

So, you know, this is -- and, as you read the rest of the article, what you'll see is that she's getting, it sounds like, you know, she's going from doctor to doctor getting medical care and her mental health is a disaster. Like, her trauma is completely and utterly unaddressed.

And, her family's trauma and her mother's and, you know, sort of the incredible stress of the situation that they're in. So, that was the first one.

The second was that Reuters did a series on neonatal abstinence syndrome and this situation of babies that are born exposed to opioids, spend weeks in the hospital. They get

better, they get well enough to be sent home and within weeks or maybe a month or two, they end up dead because they've gone home into situations that were not safe, ultimately, and where their mothers and their parents were getting no services, no support, even though they were known to have usually, you know, multiple issues.

So, care coordination, but thinking about it very broadly because, we all recognize that only so much can be done in a physician's office or in a hospital or what have you.

We really need to broaden our reach.

CO-CHAIR WHITACRE: Thank you.

Mady and then Scott?

DR. CHALK: In that regard, very many of these gaps that have been identified and what we're talking about are the same gaps that were identified in the Duals last meeting. All the ones from multiple chronic conditions, all the patient-centered measures, the trauma care, especially patient reported outcomes and then, optimal function.

So, if NQF is interested in crosscutting various committees about what the gaps are, they keep coming up, it seems to me.

CO-CHAIR WHITACRE: Scott and then Steve?

MEMBER FURNEY: And, adding on what others have said, I think in that list, we now have more than a hundred use measures, overuse measures that have been offered to us by professional societies.

So, the choose wisely list, we are adopting many of those internally and creating measures around them. I think that's fairly low hanging fruit that is great to internally benchmark and also use nationally.

As I look at this list and I try to think about what would be my highest priority, there's a single measure that has been on my mind for the last six months or so, multiple chronic conditions, trauma care, I know we're supposed to be more general and not more specific, but I will just say I've not seen a measure of polypharmacy

unless I missed it in the 350 plus 58.

But, it is a problem that affects our geriatric population that generally reflects poor diagnostics and poor treatment. And, if there is the prioritization for a measure that would be a good symptom of the disease, all of that being on that slide, that's one that I see all the time that reflects the failure of the health care system.

CO-CHAIR WHITACRE: Steve?

MEMBER FRIEDHOFF: Thanks.

Two comments, I mean quickly, I'll just kind of pile onto the overuse phenomenon and choosing wisely, in particular, is probably a good place to start there.

But, I think the other thing I wanted to bring up is to kind of expand on some of the comments I heard previously.

So, and a lot of my work, primarily what I deal with is Medicaid populations, to some extent Duals and Medicare as well. And, I think what we're seeing actually in some of our State

partners is that some of the things that we're being judged on as a health plan are real life outcomes.

So, employment rates, homelessness rates, re-incarceration rates, now granted, some of those may not be as applicable, hopefully, in, you know, a pure Medicare population, but, I think, again, it speaks to more life outcomes.

And, even in Medicare, we're also evaluated using the health outcome survey which, you know, has lots of different questions, some of which are things like, you know, compared to a year ago, is your health better or worse? Is your functional status better or worse? Is your diabetes better or worse?

And, I think, while it gets very complicated, it also speaks to how health care is much more complicated than individual measures like this in the social determinants of health care having such a huge influence. I mean, you know, Cindy, your example was a perfect one.

So, I think those are tougher ones to

tackle, but in the bigger picture, especially with care coordination within the health care system and also other support agencies, it's, you know, something we probably should consider, too.

Thanks.

CO-CHAIR WHITACRE: Thank you.

Next is Rachel, Peter and then Marci.

MEMBER GROB: I don't want to compete with the siren.

Wonderful discussion. I just have a few thoughts to add in.

One is to pick up on a conversation we had yesterday and I already heard Kate refer to it again, but just so it's captured here, the idea with the patient centered measures of sort of taking them out of a silo and creating some composites.

I realize that that's a very complicated methodological task, but if we have resources to invest in addressing gaps, part of what we want is efficiency and stronger measures.

And, while I'm, you know, of course,

all for all of these patient centered measures, I'm also really interested in seeing our measurement evolve to match what I think we're seeing as a growing phenomenon in care which is more activated patients, more engaged patients, a health care system that wants that, understanding that issues of value and cost are most wisely addressed by making the patients partners to the extent that we can and sort of like a power shift in the like sociology of our health care system.

Which, I think our measurement would be do well to evolve towards as an innovation. So, I'd like to see us do some of that.

I also think, from a patient's perspective, and those of you who have been here in past years have heard me say this before, but I'll say it again, that we know that patients really want that qualitative or narrative data, those comments.

I heard some of the presenters yesterday mention that. So, in thinking about measure gaps, I think our measurement doesn't

give patients a lot of the narrative data or really any of it yet. And, that's another innovation that I'd like to see us experiment with.

And then, finally, I really echo what several people have said about choosing wisely and, I think we have a lot to learn about how, on the public reporting side, I know we're going to get to that discussion, but it's connected to the gaps, you know, what that really means for patients on how we create an ethos that helps patients understand those measures as vitally important to them, not just to sort of saving money for somebody else.

So, I think developing measures and a strategy that take what we're learning from choosing wisely and the tremendous work that the professional societies have done and bring it more into the public reporting realm, building on some innovations that some of you have already been experimenting with and then, thinking about that very strategically.

CO-CHAIR WHITACRE: Thank you.

Peter?

DR. BRISS: I would be remiss, I've co-chaired the behavioral health committee and when we were talking about gaps where mental health and behavioral health always get underemphasized relative to physical health and relative to risk, it's a burden. And so, that's something to keep an eye on.

The other thing I would say is, I sort of I love choosing wisely, but I don't think it's the thing that's going to move the needle on overuse or cost.

So, I don't see how we can ever make much progress in a global sense from trying to push one overuse of one service at a time. There are just too many of them.

And so, I would echo, I think what Bruce was saying earlier, I think we need some much more global measures. We probably need some version of a generally accepted total cost of care measure and some way of pairing that with

measures of good quality so that people could get some sense of what value am I getting from my investment. I don't see how we can ever get there one service at a time.

CO-CHAIR WHITACRE: Thank you.

Marci?

MEMBER NIELSEN: I'm going to not repeat all the good things that people said, at least try to. But, I do want to repeat something that Janis mentioned yesterday which is that we have as the unit of analysis in many of these measures. And, I know we've got the group level measures, but we don't measure at the team level.

And, as we're trying to change care delivery, what's happening with the multiple measures we have is that the physicians or the nurse practitioners, the person being measured, feels the weight of the world on their shoulder and begrudges all of these measures.

But, if they felt like we were starting to measure how the team managed some of these episodes of illness, I think that would be

very important.

The second piece of that links to how providers see the world is they are feeling incredibly burdened in many, many of specialties, certainly in primary care. And, what are we doing about that?

We don't measure -- I mean I'm going to say something about patient experience in a minute, but what about provider experience? And what do we know about what correlates between providers and their satisfaction in their job and whether they're burned out and stressed out and the extent to which that impacts patient experiences?

And, we know there's some correlation, but we don't have great measures because we don't have a lot of them.

Which links to my final measure regarding patient experience and the CAHPS survey and everybody knows that CAHPS is important, but it's not sufficient. The people who read CAHPS are health care providers, they are not

consumers, by and large.

The measures that we use for patient experience are not driving consumer behavior in any real way and I don't have the magical answers, but we've got to figure that out because patients don't feel engaged.

And, importantly for those folks who are -- have behavioral health issues or multiple chronic illnesses, many of them can't and won't ever fill out a CAHPS survey.

So, what are we doing to get the proxies involved? And that's a terrible name, the proxy. Well, how about family and care givers? And what are we doing about family and care givers' experience?

And, there's -- I can't believe there's not a single person in this room who hasn't had their own experience. But, my 51-year-old brother at the beginning of the summer was diagnosed with what he thought was the flu, quickly found out it was cancer. He was gone four months later.

And so, I got like a CLEP test -- that's him telling me right now to shut up.

And, we have lots of illness in my family, so again, we've all been in these shoes, but I felt like in four months' time, I got to see it all from the family care giver, my brother was brilliant but took terrible, terrible care of himself, didn't have a good primary care provider.

To see that range, wow, was I wrong about what patients and families care about and this is what I do for a living.

So, back to Rachel's point about collecting the narrative and using the narrative to help us understand the quantitative. We are so stuck on the quantitative and providers are so frustrated by it. We are missing the forest through the trees when it comes to how we actually take care of a patient and their family so that they do something differently.

And then, the patient and the family goes away when the person's gone and I haven't

circled back to the nurses on that oncology unit who I am so indebted to.

So, how do we make those people who work tirelessly feel valued in this process? We just throw more measures at them. Something is wrong.

CO-CHAIR WHITACRE: Thank you.

Bruce?

CO-CHAIR BAGLEY: Yes, when Janis mentioned team-based care yesterday, I wanted to say something, it just didn't seem like the right place to, but now, it's open forum.

You know, I think your first two points actually can drive more team-based care. In other words, as a physician, I am beginning to realize that I can't do well on measures without a systematic approach, a team-based care.

And, you know, that would provide me, by the way, with better satisfaction about my work because I wouldn't feel it was all on my shoulders.

So, it's really kind of, it is in some

ways part of the solution. All you have to do is get physicians, clinicians to recognize that the only way they're going to do well at this stuff is with team-based care.

CO-CHAIR WHITACRE: Thank you everyone. Great discussion.

David?

MEMBER SEIDENWURM: To make one point, by the way, thank you so much for that. That was, you know, just a magnificent point to make and thank you.

Just maybe to go back a little bit to the mundane, we do need something about data interoperability. The power of even just rudimentary claims data at an all payer statewide level compared to the piecemeal data approaches that are in the hands of any one payer or any one provider is just extraordinary.

And, you know, I don't know if, you know, Rob's going to get fired or me because the radiologist is agreeing with the consumer, you know, advocate. You know, so I don't know if

something's going to happen bad here.

But, we've just got to have -- we've just got to put this data to use, you know, in a humane way that allows us to improve care at the level of the community.

And, it's just amazing what is out there, but that we just can't get to because it's so fragmented. And we need, you know, I'm no major fan of, you know, government regulations, blah, blah, blah, blah, blah, but this is one area, if we as a society are paying for this stuff, then we ought to be able to use it and that the commercial enterprises, including my own that are the repositories of these things, you know, have to commit to an architecture of sharing so that we can learn from this data that's been collected.

CO-CHAIR WHITACRE: Well, thank you so much. I can't imagine a better discussion. I wonder if I could invite questions or input from CMS or from the MAP staff? Is there something more you would like to know? Can we add to this

discussion?

MS. AUTREY: No questions from me. I think that was a lot.

DR. WINKLER: Kate actually apologized that she had to step out for a phone call. But, I think the one thing is, is we've all had a chance to talk. I heard some common themes, but do you feel like you gave CMS a sense of priorities? Because, their resources are not limit, you know, limitless.

And so, do we feel like we, you know, a lot of wonderful things, no doubt about it. It was, you know, I hope Santa's listening. But, do we feel like we've provided priority? Like, do this one, two, or three things first, because they're urgent.

CO-CHAIR BAGLEY: The one thing I heard from the conversation, about a number of different measures, and just by the nature of how we gather measures, they tend to be very specific, like, the pathology reporting measure, you know, why shouldn't it be for all reports?

So that kind of thing.

Anytime that they can make it as broad, as possible, to provide, to give guidance to all providers about all types of things, would be a clear one, in my mind, anyway.

CO-CHAIR WHITACRE: Peter.

DR. BRISS: I agree with that. And at least, at least three people around this table, sort of, outed themselves as lumpers, which is a new world indoor record for a measurement table, right? Right, Andy?

And so, so you could make a case for, you could make a case for, sort of things that apply broadly ought to be of, generally, of higher priority than things that are more narrow.

DR. WINKLER: Okay.

CO-CHAIR WHITACRE: May I make a proposal? It sounds like we need to be finished by 3:00 p.m., for most people to make flights, is that correct? The agenda goes beyond that, we have time beyond that.

So to prioritize, in my mind, I really

need a list. And I've got a list of multiple things here, but I have some things missing from the list.

Could we take a couple of minutes to create, while this is on the screen, a new list? I missed, I don't see appropriateness of care, or intervention. We've asked about polypharmacy.

Is it okay to take the time? It might take us 15 minutes to pull from this list and just start to add things to a new list and that would be our prioritized list.

Because, I still think we have many great ideas, but I don't have a sense that we have a consensus on, this is number one, this is number two, or these are the top three, these are the next three, and those are the next three.

Can we do that on the screen, just real-time? So would that be all right with everyone? Just as, I mean, they're asking, the question was prioritization.

We have great ideas, no one disagrees with that. We have a multitude, however, of

ideas and I think there's an opportunity here, because I know, in discussions, and this may come up, we've asked for what's the feedback from, how do we know that our, our concerns are being heard? We'll have a list. Is that okay with everybody? Okay, super, proceed.

MEMBER NIELSEN: Might I make one additional process recommendation to Eric, and that is, there was a list that they generated. You could, simply, tell us, pick three. You only get three.

Everybody look at that list and we can have a new list, and raise your hands, who thinks that ought to be, like, if you want a quantitative number for what CMS has already prioritized, and then give us an opportunity to do a new list.

DR. WINKLER: Yes. Just to make sure, that list was your list from last year.

MEMBER NIELSEN: Oh.

CO-CHAIR WHITACRE: Know that we have --

MEMBER NIELSEN: Damn.

CO-CHAIR WHITACRE: -- CMS' list and they're asking us for one, it sounds like indirectly, through the MAP, so this is a real opportunity, in my mind, I just can't think clearly enough to prioritize all these various topics and understand, as well that this has been, you know, I have my prioritization, but I don't have a sense that this is what the group consensus is, so we have an opportunity, with informatics, we can just put one screen, one slide up, put another slide up and we'll make our own list. Is that all -- hands are going back up again. The slides are not up. Is this a comment about process, or prioritization? Robert.

MEMBER KRUGHOFF: I guess, I think we should deliver a broad message and a list-by-list, you know, and a list message, and I do think they're quite different. And I think we have to say, there's some real underlying system changes, in terms of availability of data. All right --

CO-CHAIR WHITACRE: I think it's up to us what's on the list, is that a -- we can add, we can add broad priorities, as a --

MEMBER KRUGHOFF: Okay that's fine.

CO-CHAIR WHITACRE: -- as a topic.

(Simultaneous speaking.)

MEMBER KRUGHOFF: That's fine. But, to me, it's very different from saying we need, you know, now I've lost some of those items on the list, but, you know, some of those are quite specific, as opposed to, you know, things that I think need to be done, which are, you know, just, you know, have a meaningful use system that actually produces data and --

CO-CHAIR WHITACRE: The prioritization may be about process, it could be about fixing IT problems.

(Simultaneous speaking.)

MEMBER KRUGHOFF: Okay.

CO-CHAIR WHITACRE: Or, it could be about deliverables from the MAP, which are more specific.

DR. WINKLER: Let me, let me, also just say that, I think, the priorities, which was the specific ask, are important, but in the context of the writing that we do with the deliverable, we can certainly mention other things, so I don't think they're mutually exclusive.

MEMBER KRUGHOFF: Yes.

DR. WINKLER: But I do think we were specifically asked for priorities, and it would be useful to be able to deliver that, that ask, specifically.

CO-CHAIR WHITACRE: This could be like our individual measures. We'll have some measures that we think are gaps and we can prioritize them and say, well we have some overriding comments about this, you need to fix informatics, interoperability, you need to fix public health, whatever.

Those are comments. They've asked for, they've asked for a list of prioritized gaps in their measure set. We should be able to

deliver that.

MEMBER KRUGHOFF: Okay, so are we deciding that, that we talk about the, we talk about those more specific things, and then hope that the comments convey the other thing, or can we actually say, a priority has changed the whole damn system?

CO-CHAIR WHITACRE: That's a hard one for them to address. I mean, so --

MEMBER KRUGHOFF: That's my priority.

CO-CHAIR WHITACRE: -- can we show the list and then have a second slide, or bring two lists up, so we can just pull things one to the other?

There you go. So if you can just spread, you can either make two columns in PowerPoint, and then we'll bring things -- so this is the existing list from last year, this was our list.

I would maintain, there are some things, you'll have to move them all to one side. Hopefully, it won't be too small. They've asked

us to prioritize this and additional new topics.

For example, I don't see appropriateness on this. There may be some things that are missing from this list. So if we pull that over, you'll have to display it, maybe -- yes, Bruce?

CO-CHAIR BAGLEY: So I'm going to continue my theme. I think there ought to be some measures of health, or something that promotes health.

And, to be more tangible, there's actually measures under development and use, and in some places, around preventive services, for instance. And, you know, why isn't that on the list tonight?

I'm especially thinking about MSSP. You know, if you're actually having something that's supposed to take a global payment around the health of a population that would be an ideal measure to use in the MSSP.

CO-CHAIR WHITACRE: So one, one thing on the list would be global health measures?

Yes, Barbara.

MEMBER LANDRETH: This might address some of the patient-centered aspect, as well as interoperability, but what I would like to see is a global patient portal that's independent of any EHR system that's owned by the patient that is a repository for all of their medical information that goes with them anywhere they go, and contains information that providers can access and can be used for shared decision-making with patients and providers.

CO-CHAIR WHITACRE: I think these are great ideas. We're at a very high level. We need deliverables that will work, tell me if I'm wrong, Sophia, that will work within -- this, these are important ideas, so they belong on our comments. We need to prioritize measures, in a way that's actionable, for CMS, for the upcoming MIPS and MSSP Program.

MEMBER KOPLAN: Hi, this is --

(Simultaneous speaking.)

CO-CHAIR WHITACRE: Hello?

MEMBER KOPLAN: Hello?

CO-CHAIR WHITACRE: Yes?

MEMBER KOPLAN: Yes, hi. One area that I don't see on this list that, I think, is important, since over 30 million people access this form of care, would be emergency medicine and urgent care.

It's especially growing in the elderly population. So for, I think, emergency department specific measures would be something to think about.

CO-CHAIR WHITACRE: Okay that's added to the list, emergency department. Diane.

MEMBER PADDEN: Okay, another area might be tele-health. When we think about communities, rural areas, people who may not have access and how they're getting their care, tele-health, or through that means. That's, kind of, out there, as well.

And, I guess, I'd like to make a point about the global health measures. As we speak again about, overall, the health of the

individual and what that means, particularly, if there are lots of conditions.

And to Luther's point, about patients' beliefs or their culture, where they're at. So we may think of global health at, at a particular area and what's important to us, but we really need to also think functionally about where the patient is.

Because, as providers, we don't want to impose our views on what health should be for them. So if they're able to walk a few feet that might be great, but we might say, expect that they're going to walk a half a mile. So I think we just need to be really careful about imposing our own beliefs.

CO-CHAIR WHITACRE: Great. Thank you. Jim.

MEMBER PACALA: Yes, similarly, goal-oriented care. Patients getting the care they want and not getting the care they don't want.

CO-CHAIR WHITACRE: Terrific. And so

we have expanded the list. I'm sorry, David.

MEMBER SEIDENWURM: One way to operationalize -- perhaps in the shorter-term -- something that Barbara was talking about, might be, you know, just some metric around specific data elements that need to be shared, you know, beyond what's in the Meaningful Use Program.

But, you know, we proposed an image sharing metric a few years ago and, again, that didn't make it for various reasons. But, you know, perhaps, if we could define a specific data sharing metric that would be, that would be used, we could operationalize a lot of what Barbara was saying without going the whole way.

CO-CHAIR WHITACRE: So we have -- Peter.

(Off microphone comment.)

CO-CHAIR WHITACRE: Behavioral health.

DR. BRISS: I think we heard team-based care; is that fair to put on the list?

CO-CHAIR WHITACRE: So we've expanded the list, which is great. So we still have to

prioritize. Because, I'm thinking, and help me if I'm wrong here, they've asked for a prioritized list.

They've got a, probably, a bigger list, internally, at CMS. They're asking us what we think is important to address; we pick our top three, or top five, from the list. Amy.

MEMBER MOYER: I'm going to throw something out about that team-based care. So when I get my goals for the year, there's not necessarily an expectation I'm the one who's accomplishing those goals, but I'm accountable for those goals.

So in some ways, having a measure that a physician is accountable for, can be team-based care. We're not saying you, the physician, have to do these things, you have freedom with how to accomplish that.

And I think, in some ways, it's partially how we think about it. We're not saying you, personally, have to do that. And, you know, if my team doesn't meet their goals,

it's still on me. But, I think, in some ways, I view that similarly, I guess.

CO-CHAIR WHITACRE: This is all valuable. Robert.

MEMBER KRUGHOFF: David, would you clarify what you were talking about data sharing and other folks that talked about, you know, having access to your own, I guess, your own medical record?

That's part of it. But, I guess, is there also a part where, where we evaluate the physician on whether the physician is making sure that that record is available to you, that record is shared with other doctors and that -- and it's shared with a community-wide, you know, a nationwide database.

And I'd like to push for all those things. And physicians do have a fair amount of control, as to how far they're going to push down that path.

And, you know, I think they should be held accountable for trying to find electronic,

you know, medical records system that, if Epic won't do it for them, then get another one or something.

CO-CHAIR WHITACRE: So perhaps another way to go about this is the reverse. I'm having trouble prioritizing. So let's do the reverse. Let's take things off the list that we think are the least important.

And I would propose measures for specialties with few measures. We already have 50 new, new ones, and that's already on the radar screen.

So yes we think it's important for those specialties, but to be honest, in all fairness, they probably should have been doing their work behind the scenes, developed a QCDR, be working on their own measures. So let's take that off the list. Can we agree on that?

(Off microphone comment.)

CO-CHAIR WHITACRE: No, boo, that's bad? You guys need more measures? You're like 50 to 51, right? So what else is already being

addressed, or is a methodology that we can put aside? Cancer outcomes might be high; it's a big ticket item.

MEMBER LANDRETH: I wonder --

CO-CHAIR WHITACRE: I'm sorry, go --

MEMBER LANDRETH: -- since we have some measures around end of life, I mean, it's not that it's important, but if we have to prioritize, we already have some around advanced care planning and advanced directives. That may be that could, since we see a new measure compared to last year, maybe take that off.

CO-CHAIR WHITACRE: Is that reasonable? Okay. Who else? I'm sorry. Steve. I'm watching the list.

MEMBER FRIEDHOFF: You know, just comparing last year when I wasn't here, to this year, I'm kind of seeing some overlap between the patient-centered measures, and then -- looking on the new list -- global health measures and goal-oriented care.

I don't know that they're identical,

but I see enough overlap there that it feels like what the group prioritized last year is similar in that space to what the group's prioritizing this year. So I don't know if there's a way to bundle them up, a little better, but they feel like there's a lot of overlapping circles there.

CO-CHAIR WHITACRE: Which might be more actionable for CMS, which would lead -- and I'm thinking not just CMS, but measure developers.

Because if we prioritize this list, it seems, to me it ought to be useful to measure developers. They say, hey, if I want my measures to be accepted and put on the list, I'm going to do one that reflects X, Y, or Z -- it could be cancer care, could be trauma, could be team-based care. Which is the more actionable element? Bruce.

CO-CHAIR BAGLEY: I want to make a process suggestion. You know, we're sort of trying to do nominal group process without doing it, so the first step is to brainstorm.

So I would suggest that you all take a minute, or two, to think about, on your own, what should be on the list is not on the list. We, sort of, did that a little bit. That's the first step.

The next step is to give you three votes, or however many votes, as Marcie suggested, and then, we actually do it without dots, by raising hands, if you're -- if everybody's honest, we can do it that way.

So you might actually do a regular nominal group process. Once you're satisfied with the list and once you've kind of refined the list to the, you know, the proper categories, if you will.

CO-CHAIR WHITACRE: Great input from my Co-Chair. We're refining the list. But, please, Rachel and Stephanie, and then Barb.

MEMBER GROB: So I just have a further clarification, and maybe this is from CMS, are you wanting from us measure gaps like substantive areas where we don't have adequate measurement,

or are you wanting gaps in measurement capacity, like, that would speak more to what the data sources are, or whether we could develop composites that, you know, that rolled up both shared decision-making and patient experience and other kinds of outcome measures, or are you wanting a little bit of both? Because our list is also a little bit of a mash-up, and those really are two different things.

And I know CMS has not a gazillion dollars but some resources to do this, so I'm wondering, are you going to do both, sort of, measurement capacity building, as well as investment and specific measurement areas of substance?

MS. AUTREY: Thank you for the question. For this, the content of this discussion, the former was really what we were looking at.

Not that -- not that the capacity and the process is not important, because we would like that in the notes and information we get

back from the summary, but for this, this discussion and the priorities, the former is, really, what we're looking for.

CO-CHAIR WHITACRE: We're looking at topics --

MS. AUTREY: Condition.

CO-CHAIR WHITACRE: -- really within -- terrific.

MEMBER MOYER: I'm trying to help you out, Eric, I'm going to take something off the list. Trauma. United States does trauma better than anything we do, and it's going to cost a lot of money regardless.

Are we doing inappropriate trauma care? I don't know that we are. What we don't do is primary care very well, and so I would suggest that we take trauma care off of there.

CO-CHAIR WHITACRE: Sounds like we're in agreement. Stephanie.

MEMBER GLIER: So I don't want to rain on the parade, here, and I think this input is useful, but I also think it's going to be

haphazard, based on the people who happen to be sitting at this table and the things that we happen to have in our heads at this moment.

And, short of doing a really comprehensive review of the full MIPS framework spreadsheet, along with all of the measure concepts that everybody knows --- that anybody anywhere knows are under development at this moment.

I think it's difficult for us to really give CMS a comprehensive list of where we think the gaps are, based on the measures that are actually available right now.

I think -- I think it is difficult to say that, these priorities are universal, in any kind of a way, because they are just, sort of, the scraping off of our brains, at this moment.

So I don't want to slow us down here, if people have really good ideas, but I'm, sort of, skeptical about the output of this 15-minute process.

CO-CHAIR WHITACRE: Understood.

Please, Scott.

MEMBER FURNEY: I can't think this quickly. Akin to the point that was just raised by Stephanie, this is an incredibly complex topic.

I think the guidance that we need from CMS, are you looking for major content areas -- as most of the things listed last year were content areas -- or do you want us to dive into the 350 measures and tell you which ones that are missing that would be higher priority?

And, so if we're prioritizing content areas that we think are missing in general, that's a different question altogether than if we're looking at individual items.

MS. AUTREY: I think the content areas would be something that we would want to hear from.

MEMBER FURNEY: Okay. The follow-up I would have then is I don't think this can be done quickly; in a way, I think we can get some ideas up, but I agree with Stephanie.

I think that this is a better process to be done deliberately over a period of time, so I think we have some ideas up there, but I don't know that we can come to a conclusion to give CMS a list of priorities in ten minutes, safely.

CO-CHAIR WHITACRE: Couldn't agree more. It's to jumpstart the process.

MEMBER FURNEY: Okay.

CO-CHAIR WHITACRE: The question is, we can all take it home, as homework, we can turf it to another community, we can review, you know, other spreadsheets, the question is: how to move forward to answer the question? It's a great question, and we should be very, very, you know, honored to be asked that.

DR. WINKLER: One of the things I can propose is, given lots of good ideas, but concerns about process is, indeed. This is going to be a topic for the Coordinating Committee, in January, to talk about how MAP -- not just you, but all three MAP groups --- should be addressing this and perhaps taking both.

You know, some of the ideas, I think, do help CMS with the caveats that you don't feel like, you know, doing it off the cuff and that, you know, at the end of two days of work is really a particularly, you know, well-thought-out process, and so that feedback -- in terms of how do we go forward -- is maybe not just for this workgroup, but is across the entire MAP and will include the other workgroups which resides at the Coordinating Committee, and it is a major agenda item for them, for January.

So I'm going to take the heat off of you, because I think you have raised issues that are particularly important. You know, I heard over and over a couple of things, you know, around the patient-centered measures, around outcomes for function and symptom management, you know, you said that like 100 times yesterday. You said it 100 times today. This one isn't hard to figure.

You know, appropriateness has come up many, many, many times. So I mean, I think there

are a couple, to me -- two, three, four top themes --- that are big picture that have been reiterated over and over.

But, I think, the feedback to needing a process across MAP to have, sort of, a way of thinking about gaps and how things should evolve, is something bigger than any of the individual workgroups, or something that -- and something that needs a little more structure and process to support it. Is that reasonable?

CO-CHAIR WHITACRE: Rachel, and then Robert.

MEMBER GROB: I think that makes a lot of sense, what you said, Reva. And, just as a matter of historical look back, since I've been here for a few years, I have heard this workgroup over and over -- despite the fact that, all of you are so busy and this is, essentially, a volunteer activity -- voice of strong interest in this kind of proactive activity as a complement to the more reactive.

I don't mean that in a derogatory

sense. But we, basically, react to the MUC list that's been processed by NQF, and this is sort of another function of the workgroup, and I've just been impressed by all of you, my colleagues here, at how much interest there's been in that.

I have that kind of interest, and so I do think that if NQF and CMS asked us to do this, not on a time frame that's so quick, because we have a lot of time before the next MUC list comes out in 2016, right?

Like, we could take the time and have a whole day meeting and have some evidence that we consider, so that we're not making a sort of ad hoc decision. I agree, totally, with what you said, Stephanie; it deserves our careful consideration, so that you're not getting, basically, a bunch of, like, anecdotal impressions from people who care passionately about it, but don't -- haven't considered it yet.

CO-CHAIR WHITACRE: Robert.

MEMBER KRUGHOFF: Yes, I mean, I think we can very usefully give some sense of what we

think are, you know, some of the priority areas right off here, and the fact that we have them up here and we've altered them a little bit, I think, is already -- it would already be useful to CMS.

I think, I guess, and I may be the only voice here, I'd like to know if I'm the only voice, who says we also have to say that, we have to say, we've sat around, I'd like us to say, we've sat around for, you know, a couple of days and we've thought about this all our lives.

And, and we think CMS has to, you know, its highest, in my view, its highest priority is to change the underlying data systems to really improve on the, you know -- and so this meaningful use tool and, you know, to me, is a very big deal.

Things like that, that are really possible that can make a change across all kinds of different conditions and all kinds of different patients, et cetera, but getting more data together.

And, you know, that's just a -- that's just a shout out, it's not something that is that concrete, but I think it's important. I think it would be desirable for a group like us to say, you know, we've sat around here and we're trying to do this and we're trying to deal with your individual measures one at a time, but you need to change.

And you need to make --- or you need to make underlying changes in the entire data system, and we think that's very important. And so, you know, that's -- that's a different kind of job, but we really want you to do it and do it -- and put as much resources as you can in that direction. So it's not just giving them a set of measures.

CO-CHAIR WHITACRE: Great. Thank you. I knew I could rely on the wisdom of the Committee. Cindy.

MEMBER PELLEGRINI: Just briefly, because -- and this is a little off topic, but Reva, since you've mentioned that there is going

to a Coordinating Committee meeting in January -- there were some other things that I just wanted to make sure that do get captured, and maybe even considered or transmitted to that group for their meeting, which was the thoughts about changing the MUC process for next year to improve it.

So the ideas that we came up -- that we suggested about additional voting options, you know, and around, perhaps, tiering the measures between those that are really ready for prime time and those that aren't.

And then, I also wanted to throw out there the idea, you know, I think we're all very sensitive to the fact that, sometimes when we defer action on these things, that's putting it off for a year or possibly more. Should we consider, don't throw things at me -- you know, a mid-year MUC process? Half --

DR. WINKLER: It --

MEMBER PELLEGRINI: Half the work at two meetings.

DR. WINKLER: Yes. The, sort of, last

question. I can make a slide of it, or put it as a formal general item and we always ask is process improvement, so you have been offering them and, again, and we are hearing them.

Some we can just take and go, yes great, and, and put them into play, you know, and some we can take to Coordinating Committee, if we feel it's something that's going to be across MAP to all the other workgroups. So your recommendations, suggestions are quite welcome, and we're certainly open to them.

CO-CHAIR WHITACRE: I did want to add some other things to the process. I went around the room asking people to make some notes. Clearly, in my mind, it's just hard to believe, over the last couple of days, what I've heard from, you know, a group of interested, engaged, insightful people, all the different comments.

We've got a direct line to CMS, in terms of -- in terms of our opinions and insights, and we're missing the measure developers. I mean, it's a huge loss.

To be honest, ophthalmology, without Scott, I'm not sure what we would have done with those measures, how we would have understood them. I think the votes and recommendations could have been different.

And I do understand that an invitation goes out from CMS and/or from the NQF, letting them know that these will be presented.

But, I'll have to tell you, that based on my quality experience -- because I represent the ASBS at AMA RUC -- when it comes to money, the people are in the room. They're in the room, with multiple consultants, and I just can't believe that we think money is more important than quality.

We would have had a much different understanding of many of the measures had the developers been here -- and been here, ideally, in person.

And I understand that represents cost and time, but this is important activity. So the single most important change I would make --

speaking as an individual on the Committee -- now would be to have the measure developers here when their measures are developed. Scott.

MEMBER FRIEDMAN: So, this is my first year, again, I guess, I've said that seven times. This is, if I've learned one thing is you have to have the measure developer and a clinician that has expertise in the field in the room.

And if they don't, and Reva said, well we asked them, but they -- they -- we don't make them come. Well, you can't make them come, but dear God, this is -- this is measure development 101.

If they want to get their measures developed and put in use, they have to be here, to support them. Otherwise, you can tell them, with no uncertain terms, that the likelihood of your measures getting favorable outcomes goes down significantly.

And just -- you got to stress this to them. And cost is not an issue. We're talking about lots of money here, and this is my

livelihood.

CO-CHAIR WHITACRE: Other issues? I had one other. I'd certainly like to know what happens to our recommendations, whether it's in how the measures were changed, so I'd like the measure developers here.

And then, see again, next year, what happens with those measures, or next year, or not at all. Or, perhaps, even come back as a composite, or whatever it is, to see that there's been some change and to know where the opportunities for change are, plus it would enhance our communication with the developers, which in my mind, might improve the development process. Amy.

MEMBER MOYER: I realize we can't change this, and don't anyone throw anything at me, but in some ways it concerns that me that, now, you know, I was talking to Kate earlier and she said, well all the measures now have payment tied to them.

So it concerns me that we're seeing

measures coming through and their first real world, big time experience is going to have money tied to it, you know, which is one of the higher stakes applications.

You know, we're not seeing them coming through NQF, get that endorsement, see the experience, how does it work, it's just kind of out there. You know, we, we can't really control that, and I don't necessarily want to delay things by years and years and years. I think we're already behind, but it just -- it makes me a little uncomfortable.

DR. WINKLER: Has it been said?

MEMBER FURNEY: It could be a serious tangent, but this has been done before and we have a whole group of colleagues in Great Brittan who've run something like this for 15 years. Should we consider whether we can get input from other expert -- experts?

I mean, there are a whole set of measures that we could look at, and if we want to identify gaps in our measures, we can compare

against other more mature system's evaluation of a comprehensive system. It seems like a sensible place to start.

DR. WINKLER: Okay. I think we're -- I was going to say, are we done with gaps? Are we gapped out?

Another topic that the Coordinating Committee spent a large amount of time on, and continues to be an ongoing thing, you know, within MAP, but outside of MAP, and that's the whole issue of alignment.

And I think you all addressed this a couple of times in your discussions, which is what you're asked to do, is really think about how measures could be used, you know, across programs, so that there is a reduction in burden -- reduction in chaos.

And so we did see at sort of the last vote went back to say oh, you know, we, we need to be internally consistent to promote the alignment across the two programs, and so that was an example of that.

And so I think that, particularly, for instance, like, for the Medicare Shared Savings Program, there might be an opportunity to think about: are the measures within the clinician set -- the PQR MIPS set, whatever -- that, you know, might align well into that program?

There are, also, I think, thanks to David, brought up the issue around looking outside the traditional clinician box to measures that are being used, say, in some of the hospital programs, or the outpatient programs that end up, you know, attached to the hospital workgroup, or even the PAC/LTC programs that might be appropriate for, you know, clinicians that work in those settings, such that those folks aren't getting measured by, you know, multiple sets of measures that may be less aligned than desirable.

So these are, these are things that we really want to think about. And you have done a certain amount of it and raised a couple of good examples.

The question is: how might we further

that whole idea of alignment of the clinician measures with all the other measurement activity, both within federal programs, but then you've also heard about the core measure sets that is the public/private, you know, kind of, collaborative effort to align measures.

And that's played a role for us, too. So I think you're going to see that this is a bigger and growing issue and concern across, pretty much, all measurement enterprises.

And are there ideas that you can help us understand how we might better support that -- those alignment efforts -- in terms of how we bring information to you, how -- how do we get our hands around addressing that question for clinician-level managers?

CO-CHAIR WHITACRE: Yes.

MEMBER FURNEY: I'd be interested to hear, you know, Peter mentioned that he was able to --- HHS was able to consolidate for 30 some odd, you know, cardiovascular disease measures down to one. And so I'm curious, maybe, you

know, there's some lessons learned there that, maybe, we can take back and apply to our work going forward.

CO-CHAIR WHITACRE: I certainly benefitted from Mady's presence, having somebody from another workgroup to be able to give the insight made me think about the measures a little bit differently. Perhaps, somebody from the hospital workgroup, as well, be part of the committee. David.

MEMBER SEIDENWURM: Okay. You know, just one thing, you know, again, from the developer perspective. For example, I worked on a headache workgroup, and we had a migraine-specific quality of life metric that was applied.

Well, you know, I bet half the questions on that migraine metric overlapped with, you know, a dozen other metrics. So I wonder if we could, every time something like that comes up -- you know, some disease-specific quality of life metric -- we could at least make

sure that the -- there's some kind of preferred common core of questions that are asked, so that way we bridge the gap between what's needed for this specific purpose at hand, and also what's needed for the broader -- you know, you mentioned earlier -- the broader health metric that we think is important.

So I wonder if there's some kind of a, a market basket that we could provide people of component tools that could be used and, you know, different types of outcome metrics, different types, types of quality of life metrics that would form the common core of all of these disease-specific metrics that our colleagues and the various disciplines need, you know, whether they be dermatologists, or ophthalmologists, or neurologists, or whatever.

CO-CHAIR WHITACRE: Thank you. Oh, Mady and Peter.

DR. CHALK: Would there be any advantage to pulling together the leadership of each of the committees -- just the leadership

group -- to talk with NQF about, and CMS, for that matter, about what is crosscut?

You know, it would be very, you don't need a whole committee to do that, but you do need the leadership of each of the groups to be able to look at, okay, what's the last iteration of our measures that have been put forward, whether it's the hospital group, or the clinician group, and where, and the gaps, and look at them together, rather than in isolation from each other.

CO-CHAIR WHITACRE: I was just give a list of dates and potential time to meet with the Coordinating Committee. So I guess, they're expecting us to somehow have that discussion? They didn't tell me the agenda.

DR. WINKLER: But I think, I think one of the constraints we have is trying to do so much of this, you know, within this very narrow two-month time frame over the holidays.

So some of these ideas are something that, perhaps, we might be able to expand some

other time frame when we're not feeling quite so overwhelmed with the task at hand, but I -- you know, something definitely to think about.

DR. BRISS: So I think there are some principles that might help you, sort of -- sort of get to better alignment. So you might have heard me say earlier that broader measures are easier to align than narrower ones, right?

There are things like, I think, part of the problem is that the quality enterprise, really, at large, is too bottom-up for this purpose, right?

And so what, I mean, in some ways -- in some ways what you really need is some consensus about a -- if we could generate this sort of consensus about a balanced score card kind of dashboard, right?

I could imagine a balanced score card kind of dashboard that said we want to have high quality, we want to have good safety, we want to have patient involvement, engagement, communication, we want to have -- we want to have

shared decision-making.

And, you know, we could probably get six or eight main buckets of stuff and then, pick some -- pick some leading indicators in those buckets; I think that that would help us a whole lot.

CO-CHAIR WHITACRE: Do you mean for every measure in the evaluation process as we go through?

DR. BRISS: I mean, start -- I mean, I think you're trying to get it, I think you're trying to be top-down. I think you --

CO-CHAIR WHITACRE: Okay.

DR. BRISS: I'd like to see a top 20 dashboard of -- on which to evaluate American health care. And there is, I mean, see, this sort of gets back to an old Tom Frieden and Farzad Mostashari paper, they write about it, about, this is health care, as if health mattered, right?

You know, I think that if we started from the top and said: what are a few things we

could change, if we were really trying to drive improvements in -- in population health? We wouldn't -- we wouldn't open with a random collection of 600 NQF-approved measures and others, others that aren't yet NQF-approved, right?

And, and so, and so, and so I think -- I think we ought to, if you started with the dashboard, some of the alignment stuff would fall out, I think.

CO-CHAIR WHITACRE: Cindy.

MEMBER PELLEGRINI: So we already, actually, kind of have that. It's the often-maligned Healthy People 2020, right? So it's kind of a Christmas tree. There's no question; there's probably way too many measures in it.

But there are the leading health indicators and they're the categories for Healthy People 2020. And it would be very interesting to see how some of the measures and the groupings of measures align -- again, because that is what we

have, as a nation, identified as our top health -- public health priorities.

And then, there are other areas, like, HRSA's Title 5 health indicators, many of which align, almost, directly, or directly, in some cases, to clinician measures on things like -- or some of the existing measures, low birth weight, early elective deliveries, immunizations, et cetera, they're not all perfect.

But, MCHB went through a heck of a process coming up with the Title 5 Paternal and Child Health Block Grant measures, and it would be worth, you know, looking at other places in the government like that.

MEMBER PACALA: It's an attractive idea, but it's -- it's all going to be put back on primary care. I mean, I live in Minnesota, so I have a dashboard that my -- my clinic manager shows me every month of how we're doing in our clinic and it's all on best measures.

And, and it's, you know, it's a total of a dozen measures, or so, and I get my diabetes

composite, my vascular composite, asthma, depression, and so forth. So, you know, and some of those correlate to 2020 things, and some of them don't -- immunization rates and so forth.

So I -- while it's attractive, it's really going to -- it's really going to just pile on primary care, again. So there are some limitations there.

I'm wondering if there couldn't be a series of measures that would be common to different types of roles in medicine, or different types of providers, that would cut across things?

So for example, if a provider performs surgery, are there certain types of quality measures that would be patient-centered that would be able to, that would be important and that everybody getting surgery would want to know, and so that would be, you know, I don't know.

But I mean, and could there be a core set of quality measures that everybody, who

performs surgery, would have to report? For each, you know, and same for people who do outpatient procedures. The same for people who address mental health in care of their patient. I don't know, but something like that.

CO-CHAIR BAGLEY: Just, kind of, to respond. It's sort of where I was going before with participation and quality improvement. So if you're a surgeon, you know, do you use a checklist, do you use a timeout, do you assign site of surgery, do you do patient-oriented outcome measures, did the surgery make you better, you know, stuff like that would be far more useful than, did you close the incision with four or five sutures, you know.

CO-CHAIR WHITACRE: Oh, Beth.

MEMBER AVERBECK: I wonder if one way of, kind of, taking that would be to say, is there a way that we could have measures that follow a patient regardless of who's taking care of them over a course of time?

So you're a young kid, it might be

immunizations, it might be mental health, it might be end of life, could be co-managed with an oncologist, a geriatrician and a pulmonologist, I mean, and just for example.

But, it would be a set of metrics that read that, whoever is surrounding that patient is then held accountable. I mean, it's a different framework, it would take some work, but if that was an idea down the road?

CO-CHAIR BAGLEY: Okay, just to comment on that. I think that those of us who have been in this measurement enterprise for a long time have wanted that right from the start, in terms of patient-oriented measures.

But the way we've set up the measurement enterprise, it can't seem to get there. It's all about providers. So I totally agree with that.

And, you know, we'd have to, kind of, almost start from scratch, to some degree, about how we come up with the measures. But I think that's worth having on the aspirational list, to

have things more about the patient. Did the patient get better?

CO-CHAIR WHITACRE: Stephanie, then Scott.

MEMBER GLIER: So I think, I think that's true, but I also think there's some opportunities here for us to come, like, 10,000 feet down from 40,000; we're still too high level, but it's a starting place.

And, I think, at the risk of giving us more homework at the beginning of this, having us do more of an overview of both, where you're trying to go with the clinician programs, but also what you're trying to do with the hospital programs and the PAC/LTC programs.

So that before we start our review of the MUC list, we actually are thinking of what the goals are of those programs together and how we can make sure that there's some alignment across the goals of the way the programs are structured.

And, if there are places where we can

focus on, whether it's the same goal, you know, rolled up from the individual clinician level all the way up to a whole facility level.

Or what if there's some overlapping content areas we can focus on that are the highest priorities that we think will result in better patient care, better health outcomes, then maybe we can, sort of, have that already on our radio, as we're starting to review the MUC list, whatever it looks like.

MEMBER FURNEY: I just wanted to add a comment about, while following, having a metric that follows the patient that's patient-specific is -- is difficult, I do think one of the priorities needs to be the ability to go from acute episodic checklist, or single documentation requirements, to a continuity-based outcome measures.

So again, as difficult as the depression measure was for us to discuss and come to a conclusion on, the advance in that is that it's not just that I did a PHQ9, as I diagnosed

depression and then I, actually, was required to document improvement.

We can argue about how that should be done, but the more we can do of that, and the more we can correlate that with the long-term outcomes, so when you look at the urinary tract infections per 100,000 admission, that has baffled me as to how I -- as a primary care physician -- can prevent that. For me that's an access measure. Right?

So yes. So there really, there's a suite of things that has to be included, to be able to look at, it could impact the facility, it can impact the patient, it can impact the health system; if I have better access and I see patients before it becomes a hospitalization, I can triage, but I need to not over-treat the asymptomatic bacteria.

I need to have access to the patient, can I get in and be able to intervene before the patient gets too sick? That's our -- it's a truly comprehensive measure and what we're

measuring is the end.

What we have to do is figure out how to measure that comprehensively enough that we really understand what we're doing benefits the health of the patient and not just a number.

CO-CHAIR BAGLEY: Yes, I wanted to confess that I made a grave tactical error by rescheduling my flight at lunchtime. And I will be leaving you now. And I apologize for that; normally, I wouldn't do that, but I didn't predict quite right. So I apologize for that. There's only one airport.

CO-CHAIR WHITACRE: Thank you, Bruce, for all your help. It's been a real privilege.

DR. WINKLER: Thanks, Bruce. I mean, I think in all honesty, we've covered our agenda items. I think it is important that we do take the opportunity for public comment. Again, there are -- we've had a few loyal folks hang in there for the whole time, and so --

CO-CHAIR WHITACRE: So we would invite people in the room, or later, on the phone?

OPERATOR: If you would like to make a comment, please press star then the number 1. There are no public comments from the phone line.

CO-CHAIR WHITACRE: Great. Thank you.

MS. SAGE: Hi. Good afternoon. My name is Jill Sage; I'm with the American College of Surgeons. I want to start off by just saying that I participated in this process since the inception of the MAP, and the materials that the staff put together this year were really great, so I appreciate that.

One thing I wanted to address, which is something really relevant to the gap discussion we just -- the Committee just had, is the fact that the College of Surgeons submitted some measures to CMS this summer, which we are hoping to see on the MUC list.

And we've touched base with CMS and we're going to follow-up with them to sort of see how we can better communicate, about what they're looking for and why they're not on the MUC list.

But I did want to raise the issue that

our performance measures committee put in a lot of time and did a really extensive analysis of all the measures in the PQRS program that are relevant to surgical care.

And there was, certainly, a huge lack of relevant measures, and so what they did is they all -- they got together and they made a good effort at what they believe is the best representation in a lot of the gaps in care.

And we submitted a PQRS Measures Group, and it included three already existing PQRS measures, but then, I believe, seven additional measures. And this measures group goes across all of the various phases of surgical care, so pre-op, peri-op, inter-op, post-op, discharge, and it's really not just focusing on an instance, or a single point of care; it's really attempting to look at the totality of care.

And it was designed in a way so that the measures and the measures group, currently, are very broadly applicable to surgery, so it's

very cross-cutting in that -- in that sense.

But it was also designed so that more procedure-specific areas across those, they will, I guess, the procedure would be inclusive of all the phases, but -- so that procedure-specific measures could be added to that core set of measures.

And it really addresses the key work flows of surgical care, and it's inclusive of coordination of care with anesthesia, PCPs, and other specialists.

And it focuses, there's measures that include care coordination, shared decision-making, patient and family engagement and, specifically, a lot of the discussion in terms of some of the gaps identified last year, this measure set also has a functional status measure for frailty.

There is also measures that address multiple chronic conditions, complex conditions, and also participating in an outcomes -- a surgical, risk-adjusted outcomes registry.

So I had made the Coordinating Committee aware of this by submitting a comment, so I did speak to the NQF staff. And I realized that, you know, because of the really rapid MAP process, it would have been difficult for an analysis, or opportunity for these measures to be looked at, at this point in time, without all the additional information.

But, I am hoping that this will be discussed at the Coordinating Committee meeting, and perhaps this Committee can talk with CMS, as well, about this. But, at the very least, we would really hope for these measures to come forward.

And I'll also note that some of the measures, when we submitted them to CMS, we were hoping for some feedback, as well, so that we could have then moved forward and still can do this in this upcoming year, assuming we get kind of a green light, or we're hitting the mark, do some more detailed testing on the measures, too, so we would have that information. Thank you.

CO-CHAIR WHITACRE: As you all know, I'm a surgeon and a Member of the College of Surgeons, so I'd ask Reva to respond, or let the Committee.

DR. WINKLER: I'm not terribly sure exactly what to respond to. Again, I think that the measures that the MAP is -- deals with, as the task, as the work in front of us, or the measures that are given to us, by CMS on the MUC list, so -- and that's, really, our job. And so I would see if CMS had any comments?

(Off microphone comment.)

DR. WINKLER: Okay. Yes, I mean, again, you know, the only information we have is the information you just provided, so it's a little hard for us to have something to work with.

MS. SAGE: Yes, and I absolutely understand that; I just did want to bring it to the attention of the Committee, because --- on behalf of surgery -- we really are trying to address a lot of those gaps.

CO-CHAIR WHITACRE: Yes we've got one more comment on the phone. Other public comments, on the --

MEMBER GLIER: Could you just hang on for just a second? I ---- hi, sorry, I'm here. While CMS is figuring out if they can respond to you. It sounds like the topic areas are some of the same things we talked about, and I think that's great.

You may have heard this in the discussion today, but if you're looking for additional feedback about type of measure development that this Committee would find useful, taking a patient-focused perspective and trying to work with the other specialties, who might touch the patients in their continuum of care might be valuable, so that there's a measure that goes beyond just relevance to the surgeons, themselves, but in fact is about the whole team of care.

MS. SAGE: Okay. Thank you.

CO-CHAIR WHITACRE: There's another

public comment on the phone.

OPERATOR: Sir, your comment comes from Koryn Rubin.

MS. RUBIN: Hi, this is Koryn Rubin from the American Medical Association. I want to echo, I believe, it's Robert Krughoff's comments, from Consumer Union, in regards to building the necessary infrastructure that supports interoperability.

Just having process measures that measure interoperability is not going to get us where we need. The ONC -- through their various workgroups -- has looked at some of this, through their advance health models workgroup, in terms of some of the areas of infrastructure, how to support alternative payment models and outcome measures and patient-reported outcomes measures and functional status.

Without the investment in the infrastructure, we are going to be stuck in the current state that we are in, and also, getting at the idea of position burden is, you know,

there is a real issue.

And, also, in terms of enhancing patient care, is by just doing chart documentation, in terms of collecting patient functional status is not going to, you know, move the needle on quality improvement, because it maintains the silo approach when it can't be captured in the EHR.

And, you know, they may, would be happy to provide more detailed feedback, in terms of the various interoperability infrastructure issues that need to occur to enhance quality measurement and the quality, and move the quality needle.

CO-CHAIR WHITACRE: Thank you. Are there other comments? Anyone else on the line?

OPERATOR: There are no more comments from the phone line.

CO-CHAIR WHITACRE: Thank you very much.

DR. WINKLER: I think, just since folks are leaving, everyone travel safely. Just

next steps, I mean, MAP does move quickly. The recommendations, as well as a narrative that kind of tries to pick up all this stuff, is scheduled to begin a public comment period right before Christmas -- I think it's the 23rd --- that will go through January 12th, I believe.

And then the Coordinating Committee will meet in late January -- the 26th is when it is. And then, our final deliverable, with the recommendations, are due to CMS on February 1st. The final version of the narrative for us doesn't -- isn't due until March 15th, but things are moving very, very quickly.

So we thank you, very much, for all the work you've done to help us meet these rather challenging time lines. But we've always done it, and this is year number five, so for many of you who've been around for a few years, again, thanks. There was a question? Somebody had a raised hand.

CO-CHAIR WHITACRE: Stephanie.

MEMBER GLIER: Is the Committee going

to have a, is the workgroup going to have a chance to review the narrative -- either before or after the public comment period -- before it goes to the Coordinating Committee?

DR. WINKLER: Perhaps. We'll kind of have to see what's going on. It's one of those where it gets kind of tough.

CO-CHAIR WHITACRE: Well if there are no other comments, I'd like to thank everybody for their participation. A wonderful group; I thought we had great discussions. Thank you all for taking the time.

(Whereupon, the meeting in the above-entitled matter was concluded at 2:30 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: Measure Applications Partnership Clinicians Workgroup

Before: NQF

Date: 12-10-15

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter