NATIONAL QUALITY FORUM

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MAP AFFORDABILITY TASK FORCE
MEETING

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THURSDAY
May 8, 2014

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The Task Force met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Chair Mark McClellan presiding.

PRESENT:
MARK McCLELLAN, MD, PhD, Chair
BETH AVERBECK, MD, Minnesota Community Measurement
JOANNE CONROY, MD, Association of American Medical Colleges
JAMES DUNFORD, MD, Emergency Medical Services
NANCY FOSTER, American Hospital Association
HELEN HASKELL, MA, Mothers Against Medical Error
APARNA HIGGINS, MA, America's Health Insurance Plans
DAVID HOPKINS, PhD, Pacific Business Group on Health
GERRI LAMB, PhD, Care Coordination
KEVIN LARSEN, MD, FACP, Office of the National Coordinator for HIT
DON MAY, AdvaMed
SEAN MULDOON, MD, MPH, FCCP, Kindred Healthcare
EUGENE NELSON, MPH, DSc, Population Health*
DAVID SEIDENWURM, MD, American College of Radiology
KORYN RUBIN, American Medical Association
MARGARET TERRY, PhD, RN, Visiting Nurses Association of America

JENNIFER THOMAS, PharmD, American Society of Consultant Pharmacists
RONALD WALTERS, MD, MBA, MHA, MS, Alliance of Dedicated Cancer Centers
WEI YING, MD, MS, MBA, Blue Cross Blue Shield of Massachusetts

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* present by teleconference

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

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

8:38 a.m.

CHAIR McCLELLAN: All right. I think we have a quorum for this morning. We have working microphones, thank you. And we have an energetic group to go at these very important yet challenging affordability issues for a second day.

I don't have a whole lot to add to yesterday's in terms of a review of yesterday's things. Accept to say that it was really nice to see the amount of engagement around some of these very challenging issues.

And I thought in particular the discussion that we had around framing overall, the overall affordability measurement challenge around costs was very helpful in thinking about it in terms of prices and spending. And we're going to come back to the prices piece today. And the discussion in the breakout group was all very helpful as well.

And I think there are some really

good ideas about making more use for example of the choosing wisely campaign around appropriate measure -- about measures and action on measuring progress on those issues. We may not be able to come up with exact explicit measures, but the approach the group outlined yesterday around utilization and other measures, I think was very helpful.

Today we've got some more challenging things ahead, but I'm hoping we can build on some of that same framework. So for example, next we're going to be turning to prices.

And if you keep with Aparna's formula of costs or spending as prices times utilization, what we covered a lot on the utilization and appropriate use side, and come back to more of that later today in terms of care coordination and some other areas, areas and complications and so forth.

But next we're going to do prices. So I do think this is all kind of fitting

together.

But before we dove into the price measurement and discussion, I wanted to pause to see if there were any other big things or questions or concerns that you all had after going through our activities yesterday. And as you look ahead to today.

Any particular concerns or broader things that you want to highlight? Any big themes that you want to make sure get addressed during the day today? Are we roughly on track? Going okay? All right.

All right, so onward in that case to -- we're going to talk about a number of other measure selection and gap identification areas. And the first of those is around prices. We'll go next to lack of care coordination, errors and complications. Get that all in before lunch.

But prices in some ways is easy and some ways is challenging. I think the way in which it's easy if you look at the next

slide is that we don't have a whole lot of measures to review.

As the task force did not identify any measures that could be included in the affordability to family -- affordability family to address the high leverage opportunity of prices. And given all the discussion we had yesterday around how important prices are, this is you know, I guess a bit concerning.

But it gives us more of an opportunity for a discussion. There was one staff pick in there where I guess you could characterize a reaction is kind of meh, of a price stability measure, which doesn't seem to capture it.

On the other hand, we did have a lot of discussion yesterday with that formulation of you know total cost is prices times spending, around many of the activities that are underway in private organizations in health plans, CMS and Part-D and increasingly

in other areas too, to make meaningful price information available.

We had some discussion about how different kinds of price information mattered. Certainly out of pocket or within plan payments, deductibles, copays and the like for individuals. And from the standpoint of purchasers, the total price, or the total payments for services.

So I think this is going to be more of an open discussion about answering this question. There is obviously a lot going on to try to push going forward on transparency and to try to make meaningful price information available to the public as many of you alluded to yesterday. But nothing in the way of a specific endorsed measure.

So this is a kind of ask the question are there available measures that could be included in the family to address prices that we haven't come across yet.

Are there, as we talked about

yesterday with choosing wisely, if we can't get you know, sort of a universal endorsed measure that does everything for what we want, is there a different path forward that we could highlight that would accomplish the same goal of helping people find out more about prices and in a way that's actionable and that drives better care.

So I mean this is actually a pretty important topic. But one where it's going to be more open discussion then we've typically had. Robert if you have any comments to add from you're or the staff's sense of the review of this area.

MR. SAUNDERS: And I think what we heard from the homework was that everyone felt that this was an important area. But it was just a matter of what was an actual -- were there NQF endorsed measures in this area?

So that price stability measure was actually a very specific little measure that was talking about price stability of

prescription drugs over a plan year. People didn't feel that was necessarily capturing the broader concerns about price transparency.

So I think that's a -- one of the issues here. It's really talking about some of the gaps that we may want to fill.

CHAIR McCLELLAN: And I already see some cards up, so Kevin and then Nancy and Sean.

DR. LARSEN: People that have through about this more, I think it helped me to have even a little more framing then we have. So I understand this idea that cost equals price times volume. But I'm thinking about this from an individual consumer standpoint.

And for an individual consumer, the volume is usually one. So I'm getting one colonoscopy, or I'm getting one MRI, or I'm getting one something. So from an affordability to a single individual, which I think is a lot of our charge -- I get we want

to roll it all up and that makes sense.

But from how do I help a consumer, tell me -- help me with that kind of price cost's difference.

CHAIR McCLELLAN: So I think that's a good topic to discuss and help us with putting the issue on the table of how are we even thinking about price for the purposes of this report.

Nancy?

MS. FOSTER: So I think building off of what Kevin said, I find it hard to think about price in terms of a measure. I think about value in terms of a measure, with a numerator and a denominator, and other things.

But price is price. You know, the sticker price, the actual price, whatever you want to call it. It is a number. And so I'm not -- and price transparency is incredibly important. I'm not denying that.

The work of this group is around

measures. And that's why I'm struggling to figure out what's the right role of price in terms of what we talk about at this table?

CHAIR McCLELLAN: Good. Sean?

DR. MULDOON: When we start to talk about price and have to acknowledge that nobody knows what the price of anything is, it sort of begs the question, what is the authoritative body that could require that prices be listed in whatever way we might recommend?

CHAIR McCLELLAN: Yeah, I'm not sure that there is an obvious answer to that. And maybe a related questions is for this group, given what you all are saying, what can we do to, if it's facilitate transparency, or other issues that would make more price information available, that might be outside the scope as you've heard. Maybe there's not just like one simple measure that we would support.

DR. MULDOON: Well in terms of

getting behind a price transparency view for the country, we just can get in line on that one. We're not -- I don't see that we would be offering anything new that other groups haven't said, which is basically, post a price so we can compare.

CHAIR McCLELLAN: Joanne?

DR. CONROY: Thanks. We've been thinking about this a lot. And certainly academic medical centers, we never win on price.

So you know, the price is specifically what the provider expects to be paid, which is actually different. Because we negotiate different rates with different insures. And we're going to run into some legal issues, because currently we also sign documents that say we won't disclose those negotiated rates.

So that's kind of one of the hurdles that all of us would have. You know it would be interesting if we could come up

with a metric of transparency globally like -- and I'm thinking from a consumer focus.

So are prices for whatever, meaning you know, your top five admissions, or your top five outpatient services, posted on -- in a place where consumers actually can access them. Like that gets at transparency without actually looking at the numbers on price.

So -- and I'd actually look to our consumer groups to say what are they looking for when they're actually inquiring about price. You know, what type of information do they want currently?

A lot of our states have legislated that you have to put charge masters out there on the web. But I can tell you that they're almost impossible to navigate for the average patient to really understand.

What's interesting is Massachusetts has a law that I think that you have to be able to give an approximate price

for a service within 48 hours of an inquiry by a patient. Which is also kind of an interesting approach to price transparency.

So I would agree with Nancy, let's get away from the numbers. Let's actually do something that actually promotes some level of transparency.

CHAIR McCLELLAN: David?

DR. HOPKINS: I just -- oh. You don't have your card up.

CHAIR McCLELLAN: I took mine down.

DR. HOPKINS: I just want to join the chorus on this point. I think that's exactly the way we should go. And can we not.

So I mean there's all this discussion about making prices transparent and everybody's trying to make that happen. But nobody's come up with a simple way of measuring whether it's happening.

So exactly Joanne's idea, can we not somehow craft a measure that says it's

happening?

CHAIR McCLELLAN: So you know my next question is, what is -- what's the suggestion for a path -- we don't have to come up with a final version here.

We can just lay out a pathway for it or something that goes beyond, you know back to Sean's challenge of you know, what are we doing beyond just kind of getting in line with those who are encouraging more transparency around pricing.

Beth?

DR. AVERBECK: I mean, in Minnesota can you image what we have done since an average cost per procedure, and I just pulled it up right now. So colonoscopy is anywhere from $330.00 to $1,500.00. And it includes ultrasounds for pregnancy. And so they're -- and some labs.

And so it's kind of like ADA common that we've not put it through the NQF endorsement process. But if there's interest,

we could certainly go back and say is -- should we consider putting it through an NQF endorsement?

But it's all the medical groups just saying pretty much what are your -- that's pretty much charge probably. Not necessarily what's negotiated rates.

CHAIR McCLELLAN: Yes, I guess that was one question, is it what the charge is. But it seems like there, from the measures that we talked about yesterday, think about you know again, getting back to spending is prices times quantities, or prices times utilization.

You do have a measure that's the total spending. And there are some measures, I guess they're nor endorsed, but measures that use -- that we talked about yesterday, that use standardized pricing.

And you know that would isolate the utilization piece. So you know, at least the principal, like this be composition, and

you know it seems like it should be possible to get to a measure of kind of average effects on pricing, holding utilization constant, or the flip side of that measure.

Do you all have something like that, or?

DR. AVERBECK: I mean the total cost of care measure separates utilization and price. So you can see when you get it where or not you're higher on. It's an index, it's not an absolute.

So that's the total cost of care looks as an index. But it does include price and utilization.

CHAIR McCLELLAN: So at least it seems you know, one possible direction too, is this kind of overall index of prices, you know sort of holding utilization constant, building off the kinds of measures that you have. The other direction that we're talking about is some kind of measure of how widely available relevant pricing information is to consumers

and others who might want them.

Jennifer?

DR. THOMAS: There is a -- I think a good example at least from Part-D that has posted some relatively useful information for the consumers that are selecting a plan. And obviously the monthly premium, the co-pays, looking up a specific profile of your medications to costs and tiers and they type of thing.

So not that I know that the Part-D clients are required to post that. That's part of their requirements. In the call letters I believe every year, the question is is there a measure development. And I think Pharmacy Quality Alliance may be you know, the group to look at that and move that forward.

But again, we know there's not any current measures, but that might be a good example.

CHAIR McCLELLAN: Yeah, Part-D is a good example.

Rob reminds me that I've forgotten one very important administrative announcement.

MR. SAUNDERS: So we just wanted to announce to the operator that we've started. So the web conference can move on.

CHAIR McCLELLAN: Okay. So moving on, I do see a lot of cards up. This is good. Ron?

DR. WALTERS: So I again apologize for what I'm going to say, but we might have to acknowledge in the report that there just aren't outcomes measures available right now around this particular category. And we might even have to acknowledge that there's very few if any process measures.

And when you don't have an outcomes measure or a process measure, what you're left with is a structural measure. And there's nothing wrong with a structural measure, it's kind of the place to start in that whole process.

And I've heard a couple of suggestions about structural measures, which is just basically do you -- do you have a mechanism to display prices. And then we can work our way towards yes, is it utilized and what does it contribute.

And then finally get to the outcomes measure with does it impact the actual outcome. We're going to probably have to slug our way through that process with starting with a structural measure of some sort.

CHAIR McCLELLAN: All right, thanks. Kevin again.

DR. LARSEN: A couple of thoughts. First of all, I'd like to put forward the Minnesota measure. I think it's something that's been up and live for a number of years.

It's already used. It isn't necessarily NQF endorsed, but you can search the web right now in Minnesota Health Scores and find the charges by multiple procedures

across the state. And so it's been honed and tried and tested, which is one of the big goals I think of endorsed measures.

The second is my research life was in health literacy. And health literacy really comes down to how do people understand healthcare information and make choices. That's an -- and choices that are informed.

And so in the health literacy world, we learned a lot from other kind of consumer places like nutrition labels. We actually studied nutrition labels quite a bit.

And things like the Energy Star rating stickers that you get on your appliances. So those are designed with a lot of education best principals in them.

And what they do is normalize information in a certain way to help a consumer make a good choice. They don't actually demand that the produce is any different. All they do is demand that there is some consistent labeling on the product

with often a reference.

So if you think of an Energy Star label, I was just looking at one the other day, it says here's the range of costs for this product across all appliances. Here's what it's going to cost you to run in a year. And here it shows you on a range where this falls.

Which is really similar to what Minnesota has done actually. So I think this notion of a label or a sticker or a standardized format in which people could predictably and reliably access this price information would be a great sort of starting structural measure because if we just say do it, we'll have ten thousand different ways it's done.

And we'll still have the same charge mess with problem, just now with price on the web. So I think we have to be a little bit more prescriptive and give it some frame and box and say do it in this way.

My last thought, one possibility for the future, I realize this would hard, but it would be the kind of thing I love as a consumer, is a measure of how accurately your estimated price equaled your charges at the end.

And so some measure of accuracy of your price estimation, which I know would be super hard and really a mess, I get it. I get it. But you ask doctors for really hard stuff all the time. And we've figured out how to do it. So we're not going to figure stuff like that out unless we try.

CHAIR McCLELLAN: Okay. Thanks Kevin, it's some interesting ideas, yes.

Aparna?

MS. HIGGINS: Sorry I was late. So I don't know, I feel like to some extent, we're trying to -- having been involved in the HFMA process, that we're trying to kind of talk about what took sort of months on that side to try to fit it all in in the morning's

discussion.

So in my mind to some extent, you know simplistically as I think of price, price is price. I mean I think in other areas we talk about you know, measures an denominators and numerators. But you look at other industries and you know, you buy an iPhone, there's a price associated with it.

So to some extent, I think that you know, maybe a certain amount of simplicity might help in this area compared to other kinds of measures that we talk about. So that's one sort of observation that I have.

The second is, you know I think transparency is important, but one of the things that we spent a lot of time about with the HFMA report, and actually had representatives from the FDC involved, was to insure that in the -- in our zeal to try to get further transparency, that we don't exacerbate certain issues around anti-competitive behavior.

And the FDC has guidance on this issue. They post it on their website. I'm happy to share it and the HFMA report actually references all of that.

So we wouldn't want unintended consequences of transparency. And we need to be sort of mindful you know, of that.

And I think finally, I just want to mention a couple of things. One, we just launched a survey of our members to see what plans are doing in this area in terms of price estimator tools.

I know that having looked at a number of websites prior to launching our study that you know, there are a lot of plans that are offering to their members, and in many cases they're tailored you know, third party vendors exist as well as the employers know, tailored based on benefits and so forth.

And then lastly, ACA does require making you know, price information available. So it's legislated, it's going to happen. I

guess the question is, to Kevin's point, what is you know, given health literacy issues, you know presenting information that's most useful to consumers and I think there's work to be done. But in my view, the HFMA report is a great place to start. It has good principles and addresses some of the other unintended consequences that could potentially come about, so.

CHAIR McCLELLAN: Aparna, from the survey that you're doing, this EMAC, that's one direction of suggestion here in terms of structural measures, is you know, to what extent out there do plans, providers, other organizations make transparent price information available? Is there a question or questions from the survey that you think are good at getting at that?

MS. HIGGINS: So in our survey we're asking our members, you know, not just do you have it for me, you know a tool available. We're also trying access what are

the functionality that's built into those tools.

And not just price, we're asking also about quality information. And in terms of the providers, I know that we had a lot of discussion around price versus charges. And I'm you know, very sensitive to what Joanne said yesterday and I think that's important.

You know, the feeling was that charges are not very helpful because you know in most cases, we all know there's no relationship between the charges -- charge master and the price that's actually somebody pays.

And so the report actually talks about, because cases where, you know if you are seeing a provider you know, that's in network, obviously you're help line can help you get the price information. If you're going out of network, you know it's between the patient and the provider.

And so the report actually talks

about different scenarios of you know, where -- who should be the sort of you know, giving this information to consumers when they go shopping for healthcare services. And it sort of addresses all those different you know, cases, which are highly relevant, you know to consumers as well.

CHAIR McCLELLAN: Okay Jim?

DR. DUNFORD: Good morning everybody. Just two things that I you know, feel everyday. And that is the way that a medical student orders. I think on some level, some day, we're going to have to teach the next generation of medical students something.

So I think metrics that actually reflect in a way education of value and cost are sorely needed. The other thing is, the -- because I'm not sure that the faculty at the universities are being educated with these costs.

Number two is you know, one thing

that's might be comparable in a way and it would just be a charge number, but it's the same tests costs a whole lot different to do that whether you word it with urgency or not. Everything that emerges is worded with urgency and there's a staff fee associated with that.

And the same test in a clinic down the block by the same organization from the same lab costs a whole lot less, so there's a relative scale there that could be worth at least for educating physicians and others, and maybe even in terms of shared decision making with patients about whether they wait until tomorrow to get this test as an outpatient, or wait next week.

CHAIR McCLELLAN: Don? And Don, since you weren't here in person yesterday, maybe you could introduce yourself to the group. Sorry, should have done that at the beginning.

MR. MAY: No, that's fine.

CHAIR McCLELLAN: the meeting got

started and Don is here.

MR. MAY: I apologize. I did participate yesterday. I'm with AdvaMed. And Steve Broughtman usually attends this, but he's next door in the meeting next door. So I listened in yesterday and wanted to come here today in person.

Just a couple of things, I think one of the challenges about looking at pricing information is you know, whether your looking at an average charge, or an average payment amount, if you wanted to put what is the average that the hospital actually receives, or a provider actually receives.

That doesn't necessarily mean anything to that individual patient. Because they have their own insurance. They have -- and that is going to be arranged by their insurance. So I think as we talk about pricing transparency and affordability and what this means to an individual patient, we really need to think about how do plans get

this information to patients.

Because they're the ones who have the best sense, not even -- sometimes the hospital does, but not even you know, they don't always know. But a plan will know what they have negotiated for a service at hospital A versus hospital B.

And you know, I think where transparency could really be helped, and I think there are some really good sights up. There are some insurers who have some very good information about if you go here for this, it will cost one thing, if you go here it will cost another, where they can link in what the average payment is for that service at this hospital versus that hospital. But then also what their copay is.

And so I think as we think about measures here, the plan is really a place where I think from an affordability issue, an individual perspective, that's where the individual can get the best information. It's

very difficult I think for providers to do this.

And I think it's from a plan perspective, if we can get that set definition that Kevin talked about, about what is this type of care? And maybe episodes, as we start taking about episodes, we'll start to get these bundles that start to look at it more concisely, we can get there.

But I think plans are really a place where we should be looking here.

CHAIR McCLELLAN: Thanks Don. David?

DR. SEIDENWURM: I was going to make a similar though less eloquent point about the plan being the locus of the information. Because they know a lot about where the patient is on their deductible. What the copay is for that exact provider. In plan or out. All the things you said, and much better than I would have.

And also, I think if we could try

-- with respect to communicating to the consumer as Kevin mentioned, patients are interested in stewardship of resources. I think workers understand that you know, even though the insurance company's paying for it, their employer's paying for it, which means it's part of their total cost of employment, which means it's money they're not getting.

So you know you're employer paid this much, you will pay that much would be a good break down for the patient. So they don't feel -- we have to get past that sort of insulation by insurance. Because the patient after all is paying for it.

And then as a challenge to Kevin, I mean he challenged us and you know, I think I'm as bad as the next guy at guessing how much something's going to cost, because you know it's so dependent on what plan they have. What you know, what comes up in the middle of the procedure, how many catheters you use, you know, whatever.

But I'll challenge you back, could there be a clause or something in the certification of EHRs or possible information systems that would get at, that would start to get at some of this information? Because right now, even if we wanted to get at it, it wouldn't be so simple.

CHAIR McCLELLAN: Sure if you want to take that, go ahead.

DR. LARSEN: So I -- we've been thinking of it in a couple of streams in that one is there is some emerging literature that when physicians know price, they actually make different choices. Maybe because there is some -- there is some ability by physicians to pick essentially equivalent treatments. And if price is one of the factors, they'll often pick a lower priced treatment.

So decision support for the clinicians about relative pricing. I doesn't actually have to even be absolute pricing has been shown to lower costs.

Secondly, the -- at my home institution before I came to the government, and I know in a few other places, we were looking at how we could build a price transparency tool for consumers. We were doing it because we were a safety net hospital with a large amount of uninsured and under insured people.

So essentially we were wanting to have full price transparency as people made a full out of pocket decision. But that was a moving target because there were all sorts of various amounts of under insurance, and people with really high deductible plans.

And so it's becoming possible with technology. But the amount of technologies that need to be inner connected are huge. Because you need the -- you need essentially a care plan, a detailed care plan in your organization of what is going to be bundled in your total amount of services that you anticipate for your procedure tied to your

charge master, linked to your negotiated prices, linked to the individual out of pocket cost that patient has already paid.

Now if you can put all that stuff together, it turns out you can get a pretty good price estimator at point of service. And so it's coming. I don't think it's ready for regulation. I think there are a few places that are out there that are just starting to experiment with it.

The one thing I would call out that is a potential opportunity, is the FDA's unique device identifier. So one of the challenges that organizations have had with their charge masters and comparing charge masters is you don't know when you have an equivalent durable equipment, or some kind of equivalent equipment because of the way the charge masters are linked to products.

So the unique device identifier has some opportunities to know when you have products that are equivalent. They just have

different identifying codes.

So that is one of the recommendations from the policy committee for meaningful use is to put this unique device identifier into certified technologies.

CHAIR McCLELLAN: Well that's still just getting one too.

DR. LARSEN: Correct, it's all -- these are building block steps, right. They're all building block steps and the question is which building block steps are the right ones at which time?

CHAIR McCLELLAN: So I asked Aparna about the surveys of plans, you know sort of this structural notion idea of are they providing, how well can we access whether they're providing this kind of transparent meaningful information to consumers. A lot of you have highlighted the importance of plan and the potential value of plans on doing that.

I maybe ask not to put you on the

spot Kevin, but sort of similar question for based on what you described, is there some making of a structural measure there for providers for hospitals or other healthcare organizations, or is it still too early on to be thinking about like what you'd ask in a survey of you know, are organizations providing the kinds of transparency capabilities that you just mentioned?

DR. LARSEN: I mean I think there are some opportunities that you know, I -- I'm going to start like it's things that are hard, if you don't start, you never get there.

So in Minnesota, about five or ten years ago, there was a class action lawsuit against all the hospitals for the uninsured patients getting charged the full charge on the charge master, but the insured patients getting the negotiated price. And because of that, the whole state had to come up with a way to give the negotiated price to uninsured patients rather than give the charge on the

charge master.

That meant that all of the hospitals in the state had to wrestle with this for quite a while and it was not easy. But we spent a couple of years under legislative mandate until we could finally figure out how we did an average negotiated price rate for anyone who was paying directly out of pocket.

So you could image something like that being a measure for hospitals. Again, it's not easy, but it is aiming at the right thing, people that are uninsured shouldn't have to pay twice as much, or 30 percent more than someone who is covered by insurance.

CHAIR McCLELLAN: Peg?

DR. TERRY: You know we -- when we started this conversation, I though how are you going to deal with price, and how important is it really? But as it's evolved, it seems to me that this really could be a game changer in many, many ways, the

transparency issue.

And I know it's from what I hear, it's terribly complicated. But I think consumers, and I was thinking in the Part B Medicare program that gives sort of options and people, even though they tried to make it clear, it was very -- it's very complicated, it's like signing up for medications under the D Plan. People are like what am I doing here, it's very complicated. They had to get specialists to help them, right.

So I think as you -- as we approach this, you know what works for consumers as well as providers? Because providers today are, if you were to incrementally move this, providers are really making a lot of the choices, whether its physicians, maybe it's health plans.

But down the road, how do you bring in the consumer and again, have that quality, simple, star whatever measure. And we could learn from other industries I think

on how to do that.

So those are my -- my thoughts.

CHAIR McCLELLAN: Thank you. Wei?

DR. YING: It was mentioned earlier that Massachusetts does have a law, they passed a law to require insurance company within 48 hours to respond to the patient request. I don't believe it's for all populations, it's for certain product line.

And I think part of the law is not just for say hip, knee replacement, and not just for one institution, it has to provide a couple of comparisons for the patient. And it's for patient's own out of pocket payment.

Of course it would not be one number, because we have to pay whatever the estimate is. We cannot pay beyond. If we say maximum is a thousand, that is a thousand we have to stick with.

So it's addressed some of the issues that Kevin mentioned about how accurate that estimation is. So we do provide it in

range, but we have to stick with that range.

So if there's no other structure, actually I don't like that legislation, I'm not promoting that for whatsoever, but if we want to see whether there is something put into writing and then insurance company actually find a way to do it, then that's a starting point.

CHAIR McCLELLAN: Okay, thank you. Nancy?

MS. FOSTER: Thanks. It seems to me as we're talking about price and cost and all of these issues sort of intermingled, what we're really talking about is helping people make intelligent decisions, informed decisions. And that occurs on many levels.

So just to throw one other issue into the mix here, not to take away from the importance of getting consumers the information they need, but it often strikes me in the job that I have, that CMS and other organizations propose regulations, and not

because they don't want to come up with an accurate estimate, but because they don't have all the right information, their estimates of the cost of the regulation are extraordinarily wrong, and stunningly wrong.

CHAIR McCLELLAN: I've heard that before.

MS. FOSTER: And I think we don't get -- we don't get good policy that way. So just to throw that on the table, how could we help get the right information to not only federal agencies, but insurers and others who are setting some of these big picture policies so that when they choose those policies, they go in knowing what the effect may be.

CHAIR McCLELLAN: Okay. Good questions. Aparna?

MS. HIGGINS: Yes, so a couple of points. I want to underscore the technical things that Kevin brought up, because we hear the same thing. I mean I think certainly for people who are insured, and if you're going in

network, you know plans are a great source of information.

But even with all their systems, trying to translate what's at the back end into the front end is a huge undertaking. And we've heard that when we did some preliminary interviews with some of the plans before we you know, we built our survey.

The other thing I wanted to mention, and I don't know if you guys might be aware of this, RWJF has funded a whole series of studies in this area. And I'm always a little bit leery of saying oh, yeah, let's regulate. Because I think this is a you know, this field is kind of in it's infancy, there's a lot of innovation going on.

And we still you know, don't have good evidence on you know, what is useful to consumers. And I think some of the work that you know, the RWJF is funding for example, will help shed light.

Some of the studies are actually

looking at did it change behavior? They're actually working with -- some of the studies are working with plans who have estimator tools and looking at did that actually impact you know, consumer behavior.

So, there's a lot to be learned. But I think that you know, this is an evolving field and I wouldn't want us to be too sort of prescriptive at this point.

CHAIR McCLELLAN: Thanks. Joanne?

DR. CONROY: So, you know I think we're veering into controlling prices rather than talking about price transparency. And it's been a good discussion and I think there's a lot of work going on around the country.

When as people have tried to deal with the uninsured and people who are paying out of pocket, it's considered. And there are market forces that are driving this much faster than this group will drive it. We're already seeing that.

That in narrow networks and with high deductibles, we're seeing shifts in the market already. So I think we should be back to price transparency and I think we really define what it means and who the customer is on price transparency.

I've always thought that price transparency is the ability to make educated decisions for the consumer. But I don't want to make that assumption that we're all looking at this through the patient's lense.

And then the second question is, if that is really the definition of price transparency that we agree on, then how would we measure that within an organization. And I think Aparna's right, that there's a lot of change going on in this market. And we may be premature in trying to actually get a measure out there that is probably insufficient, or drives the behavior that we don't really want.

So I would suggest maybe we agree on a definition of price transparency.

CHAIR McCLELLAN: Okay. Do you want to propose one? You sort of did. Price transparency is the ability you know, at least it's related to the ability of the consumer to make a good decision based on prices, or based on their own costs. It sounds like a start, or at least what it's aiming to do.

DR. CONROY: So I guess we need to talk about is that the ability to make a good decision, or the ability to get the information. I think it's probably the ability to acquire the information, that's price transparency.

COURT REPORTER: Sir, can you use your microphone please.

DR. LARSEN: This is Kevin. I would add something about getting your information in a consistent way. So that it's not 20 thousand different ways, because as a consumer, I can't navigate 20 thousand different ways of getting price.

MS. HIGGINS: Well, so sorry, I

know I wasn't in cue, but I --

CHAIR McCLELLAN: No, go ahead. No, that's all right, if you want to feel compelled.

MS. HIGGINS: I think in terms of getting information that is you know, needs help literacy standards, it helps consumers to understand, I get that. But I don't know that every price is going to be consistent. Because you know, it depends as you said earlier, what you're going in for, what your comorbidities are, what kind of services you're going to get.

So it's going to vary by patient based on their condition. And then it's also going to vary based on their benefit design. So I don't think you can have say one price for you know, a hip replacement and have it be the exact same thing for a replacement --

CHAIR McCLELLAN: I thought -- I don't want to put words in your mouth

MS. HIGGINS: But I don't know if

that's what you meant, so.

CHAIR McCLELLAN: I thought you meant around comparing options so that if you know, yes every patient is in different circumstances based on what they need, and what their benefit design is. But what they'd like to get is you know, if I go here, here, here, here, what is -- what's the price that I'm going to be paying.

DR. LARSEN: Yes, I'm just working in conforming format. There is absolutely huge variance, and there's going to be variance that's one of the cornerstone of the American kind of free market system is the variability and innovation.

But if you think about things like the Energy Star sticker, there's huge variance in the products, but you know you're always going to have that sticker. It's always going to be yellow. It's always going to have the zone and how much it's going to likely cost you for a year's worth of running it and you

know plugging it into the wall.

So you know there are certain pieces of information it's always going to provide to you consistently, even though the products are incredibility variable.

CHAIR McCLELLAN: All right. And that's good, and this is -- this is kind of a lively discussion, especially if we're trying to come up with a definition. I'm surprised there isn't a definition of price transparency out there somewhere that we could -- that might be useful.

Yes, see if you can -- right, so if you can find something while we're continuing this discussion that would be very helpful.

David?

DR. HOPKINS: This is really interesting discussion because we have all this agreement around the concept, and no measure. And as I listen to everybody's contribution, it strikes me that an obvious

question to ask is anybody setting a standard here, or do we need somebody to set a standard on how prices ought to be presented to consumers?

I guess we can let the market determine that. That's the way we do things in this country a lot of times. But there would be a lot of fumbling around while that happens. And there's a couple of very basic principles that I feel are very important.

One, episode based, not piecemeal. Two, all providers, not just you know, the physicians fee will be this, and oh by the way, you know, there may be a facilities fee, but we're not telling you about that because our data aren't put together.

Stuff like that. Is it for NQF or MAP or this group, or somebody to set standards like that, or not. But that's a big question. And a lot of it feeds into the concept of a measure.

CHAIR McCLELLAN: Yes. So episode

and kind of all and across different providers, I mean it's more comprehensive for the patients.

DR. HOPKINS: I mean even more complicated because you have to grapple with issues around let's talk about colonoscopy, right, a person comes -- goes in because they're primary care physician said you needed to have your screening test.

And they think there have been -- you know, that their plan was covering that, because it's preventative care. And then you know, a polyp was found and all of a sudden it becomes diagnostic.

So what are you going to tell that person before they go to the test that would be good for them to know that they might be stuck with a big copay, even though they thought that it was covered. We've got to deal with those issues too.

CHAIR McCLELLAN: Yes. So we actually did find the price transparency

definition from the HFMA report. Rob, it's a --

MR. SAUNDERS: Sure. And the HFMA report also has a good set of principals as well that I think that touch on some of the discussion that we've had.

From the HFMA report, just to read it very quickly, the price -- they define price transparency as in healthcare, readily available information on the price of healthcare services that together with other information, helps to define the value of those services, and enables patients and other care purchases to identify, compare and choose providers that offer the desired level of value.

So just to throw out that there are some -- we can leverage some of this existing work that's been done by a consensus process.

CHAIR McCLELLAN: Okay, so if there are any comments on that, it seems like

it fits with some of the things that we've just been discussing.

Helen?

MS. HASKELL: I think that is a good definition. What I --

CHAIR McCLELLAN: Oh, you don't have to comment on that, you can comment on anything.

MS. HASKELL: On anything. Well no, what I wanted to say was that I think the information needs to not just be what the consumer will pay, it needs to be global information. So what is charged, what the you know, what the insurance is -- what the employer is paying given all the caveats that we've discussed. And then what the purchaser would pay, what the patient would pay.

CHAIR McCLELLAN: Okay.

MS. HASKELL: I think all of that information is important. Not just to patients, but to the public in general.

CHAIR McCLELLAN: Thank you.

Aparna? Oh, I'm sorry, I had Sean next, but maybe I got you guys out of order. You're so polite.

DR. ADAMS: So a first order question is this, are we going to do it by episode or by piecemeal? And I'll take a view for the piecemeal.

And that is simply because if you do it by episode, you're going to be -- we're going to be stuck with a bunch of averages and a bunch of ranges and a bunch of dispersions. Even if we take it down to the hospital, the doctor level and we say what's it going to cost me to get a bypass from Dr. X, it's going to be the skate through person and the hundred complication person.

But we don't even know what the OR cost per day is. We don't know what the physician fee is. We don't know what the hours on the bypass machine are.

And so it would almost be like saying, well I want to eat, how much would it

cost me to go to Capital Grille? Well, I don't know. It depends on how much wine you have. It depends -- and you know how much are you going to cost me to go to Denny's?

You know one is cheaper, but you don't -- you're stuck with an average. So why don't we just try to somehow start with a basic menu. And then you say to the person I don't know what it's going to cost, but the minute you walk in the door, you've got this basic fee that's $2,000 and it could go up or it could go down.

But you can go to some site and find out what a lab test is, or you know, it wouldn't be a million things, but you know, say 200 things, something like that. And so again, maybe we've got to decide, are we going to want to do this by bundle, or in fact by menu.

CHAIR McCLELLAN: Aparna?

MS. HIGGINS: I think it depends on bundle versus menu on what you're going in

for. So you know, there's David's point if you're going in for an imaging, you're going in for an imaging, so it's a single service. Or if you're going in for an office visit, you know, it's a single service.

But if you're going in for surgery, then obviously that's you know, bundle. So I think the patient situation's going to vary and their need for information you know is going to vary.

And I think, I know we talked about the -- and Rob, thanks for bring up the principles that are in the HFMA report. So you know, I urge the group to consider those because I think they're very good principles. I think we're a long way from you know standards.

I think David, just because like I said, I don't think we have good evidence on you know, what information is useful and how consumers actually use this information. You know there's some studies that are going. I

think we're one more.

But in the spirit of allowing for innovation, I would think we would want you know, flexibility. And principles and guidelines to me seems a better place to start you know right now.

CHAIR McCLELLAN: Thanks. Wei?

DR. YING: Well, what we did was -- I agree, episodes is actually hard in terms of a price estimation even from -- for the consumer transparency because you don't know what will happen after the surgery. If there is a complication, then the cost is totally different.

So the most -- I think that what we are doing is more the procedure based. And I think this probably most of the current estimator that is focusing on. So it's usually our surgical procedure based, and usually it's just the facility for that inpatient hospital stay. What's the estimated cost would be.

And if we look at the usage of the current estimator that we have, the top procedure is actually is OB delivery. And I think the next one probably is the hip or knee. So it's very shoppable.

I think this word was thrown out yesterday. Not that there are thousands of procedures there, but not everyone would actually ask for a price if it doesn't matter them. Or if someone had a heart attack, who cares where it goes.

So it's more about those shoppable conditions depending on the volume. Those are probably the ones that if we put out any recommendation for the recommendation for the area of focus probably those are the ones.

CHAIR McCLELLAN: The easiest place to and best place to start.

DR. YING: Yes, to start. Yes.

CHAIR McCLELLAN: Okay. David?

DR. SEIDENWURM: Well continuing on the theme of shoppable from yesterday, and

elaborating a little bit on the restaurant analogy, how much information can a consumer absorb?

You know I wonder when you look at Yelp, you know they don't tell you that the average price of a meal in this restaurant is you know, $19.11 or $32.15, you know they give it one, two, three or four dollars signs. And you know, most people kind of want to stay away from the four dollar sign ones most of the time, right?

So I wonder if a way to approach this in a simplified manner would be to perhaps use either government or payer data bases, come up with you know, a market basket of services, and then just come up with you know, a Yelp rating. A Yelp price rating.

And then there will be other quality ratings. And I think consumers are accustomed to doing this. Employers could use this of course to choose which facilities and provider groups would be in their networks,

and so on.

But I think you get you know, more juice for less of a squeeze if you just broke it down into you know, your Yelp categories maybe. I want --

MS. OGUNGBEMI: I hate to break in, but I do want to say, in a restaurant, you have the menu you can go to and find out the actual price. This is trying to sort of bring prices out of the dark. I think it's fine to have a rating, but you've got to have numbers too.

DR. SEIDENWURM: Absolutely. And in a -- and to keep the restaurant analogy going here to the point where I think it fails, you know you are -- you know you have your trusted maitre d' you know, who's your doctor, right. You know, your primary care doctor, or your surgeon or your obstetrician.

So at some point -- at some point, we can't complete the analogy, because the consumer doesn't make that choice, they've

delegated that choice to someone else. You're absolutely correct. So that's where the analogy fails of course.

But I think you get -- you might get 90 percent of the way there. I'm not sure.

DR. DUNFORD: And patients rarely tip.

DR. SEIDENWURM: With respect to the out of pocket versus cost, I mean that's a really interesting issue. I'm persuaded by the stewardship issue. Because we, you know just by my own experience, we self insured for an employer group of I think it was about 1,200 employees.

And we did a lot of you know, education around stewardship that you know, ultimately you guys are paying for this. One way or the other you're paying for it in foregone wages, you're paying for it in you know, a lower pension contribution at the end of the year. You know and there were you

know, benefit design aspects of it as well.

But I'm persuaded by the stewardship argument. And I think in Medicare population, I think people are interested in stewardship as well. You know, even though it's you know, the government rather than their employer.

CHAIR McCLELLAN: All right, Kevin and then I'm going to try to summarize where I think we are.

DR. LARSEN: So I just want some gentle push back to the people that think we're not ready. And remind them that we've never been ready as physicians to measure quality in healthcare.

So I get why economists and people that manage plans would feel like we're not ready to measure price. It's hard, it's complicated, it's variable, exactly, exactly, exactly. It's going to be that way. It's going to be that way for a long time.

And we won't get there unless we

start. And so I would make a pitch that we have a strong commitment to starting. And I think we've identified a couple of places where we'd like to start.

One thing that I would like, on my short list would be the Minnesota community measurement experience that's already there. It already has the procedures, it already has the methodology, it's already live. It's state wide, multi-planned.

I think there are a couple of baskets that we could start with. An OB basket. I think a knee and hip basket would make a great sense combined with the other kind of knee and hip baskets that are out there for outcomes and safety and other things. They fell into our high priority areas by all three groups yesterday.

And then I'd make a pitch that we also ask hospital around the uninsured. Because I think that there's a huge number of uninsured in our country. And this isn't just

a health plan question, it's also people paying out of their pocket when they don't actually have any insurance.

And so that's also a heavy lift. I get it. But I'll tell you we had it figure out in Minnesota and it's now quite possible and state wide.

CHAIR McCLELLAN: Do you want to comment on that? And then let me -- okay, you two, and then I want to kind of try to put a sort of straw person out for where we might be. And then get some reactions to that before we wrap up this discussion.

Nancy?

MS. FOSTER: I just want to say Kevin, I get that we want to be helpful to the people who have no insurance. Particularly if they have no means to pay for insurance or anything else.

But there are a lot of different ways we can help those folks. And I'd hate to see them discouraged from seeking care by a

high sticker price that seems unaffordable to them, when they may well be able to qualify for some assistance.

So for them I'm a little -- I want to make sure that we're coupling it with information on access to all of that help. And that I think has to come wherever they can find it.

CHAIR McCLELLAN: So a lot of people turn out to be eligible for Medicaid or other subsidize coverage. Or assistance programs of various kinds.

MS. FOSTER: Right. And if they're wealthy and they've chosen to forego insurance, then you know maybe they need to pay more attention to some of the incentives in the Affordable Care Act.

CHAIR McCLELLAN: Okay. Aparna?

MS. HIGGINS: I just want to clarify. I think I -- I hope I didn't come off as sounding as this can't be done, or you know, it's already being done. I think that's

the point I was trying to make, it's already being done.

So I think what I was trying to say earlier is it's already being done. And so I put my economist hat on. Price is price, you know, all other industries do this. I think you know, sometimes we try to over complicate something that's a lot simpler elsewhere.

So I was hoping we wouldn't do that you know with price in healthcare. And I think that's the only point I was trying to make.

And I think the only issues that it's an evolving field and there's a lot of evidence that needs to be you know, established. And so let's not -- I wouldn't' want us to get ahead and say here's exactly how it needs to be done, so.

CHAIR McCLELLAN: And be too prescriptive at a stage when this still in a very dynamic and developing. Okay.

So here's how -- how about something like this, and this is not set, or anyway in just to promote, not that we've had any shortage of discussion for the last hour, or promote a bit more discussion.

There is a lot going on around transparency which we can allude to the HFMA definition, which is readily information available on price of healthcare services, that together with other information, helps define value of services enabling consumers, payers, purchasers and others to choose their desired level of value. Or something -- that is paraphrasing, but something along the lines for that definition.

So we're aiming for how well consumers are able -- and others, are able to compare different options based on meaningful price. This is a difficult issue for all the reasons that we've talked about.

But it's one where market forces, technical progress and other pressures are

reshaping and making much more meaningful price information available. And we think that's a good trend.

We don't want to get in the way of it. Quite the contrary, we'd like to encourage it, but we don't want to be too prescriptive in the process.

Things that could, that have been raised that could potentially move it forward but have some potential drawbacks too are some version of the Minnesota cost of care measure with standardized or average utilization. And maybe Beth you can clarify, or Kevin, how this works.

But this would get at average differences in prices across some you know, sort of bundle of services. Or you know, something like overall costs or costs for a condition, or something like that.

I think the downside is that this would be some work to produce. Although you know, in Minnesota, it seems to be getting

produced without too much difficulty. I wonder if there's some concerns about whether, you know, if you're giving people sort of an average set of utilization in the way that they're competing is by you know, not doing things in the typical way.

Like doing things in a lower cost setting of care or something like that. That may not show up so well in the measure. But maybe that's not really an issue.

But anyway, that's a -- that would be a measure of kind of how a provider, a provider group is doing on average. In terms of something like a Yelp rating, or something like that.

Then the other approach we talked about is so called structural measure approach. Are consumers able to get something that usefully approximates the price information that could help them make a decision based on value. And that's very individualized because it depends on the plan

that you're in and the services you want.

And most of our discussion there is focused on the role of plans in providing this information. And as Aparna's emphasized, there's a lot going on, but it's not completely settled yet.

I guess the question would be is there something like the quote, unquote, structural measures in the AHIP survey of you know what plans are doing, that might be a good way of approximately how well we're doing as a country. Or how well -- how we're doing in an area on making some kind of useful information available.

It wouldn't be -- we wouldn't want it to be too precise or too prescriptive. But it would be a way of trying to capture at least the degree or extent of which these kinds of activities are going on.

And we talked about in both of these cases, maybe starting with some high potential impact areas, discrete services like

MRIs. High volume procedures, relatively well defined procedures like delivery, hip and knee replacement, other shoppable conditions.

And then finally we've got some mention of a structural measure about hospital pricing for the uninsured, but some draw backs to that mentioned as well.

So I think that's -- we can do something from that, that could be relatively specific and bold. Or could be more speculative and directional. And let me ask if that makes -- again it's just a straw person proposal based on what we've discussed.

Any thoughts? Beth?

DR. AVERBECK: One thing we could take a look at so the cost by procedures, ADA counter procedures, lab pathology, some imaging, some office visits, and that's about 88 procedures. So that's one option. And we can certainly -- I can take that back and see if we wanted to submit that.

So that's kind of the menu option.

And then we'll have some experience pretty soon on a total cost of care, which is more of an the index option, around price and utilization. I know we've talked about the utilization part. Within the next six months should have some experience on the indexing of price as well.

MS. HIGGINS: So one of the suggestions for looking at overall indices is obviously the medical price inflation index. And I know S&P has a healthcare inflation index as well. So if we're looking sort of global macro level, index information.

CHAIR McCLELLAN: Yes, and that's done by overall and by different you know, components of here too.

DR. LARSEN: And additionally the one that the staff found, I think would be a nice addition to other price information. You know how much is my medication cost stable over the year of my health plan.

That's a nice one. But it doesn't

feel like the only one we should have. It feels like if we have five, that's an okay one to put as number six.

So that's at least my particular feeling about it. It's great, but it shouldn't be our only one.

CHAIR McCLELLAN: Yes, the votes for that were not that -- it's not impressive. It did not do well in the pre-meeting polling. And you know I had -- yes, and maybe like a second tier measure.

I would like to make sure that we have a strong focus on you know, something that's a first tier.

David?

DR. HOPKINS: I like your proposal. I was just wondering, you didn't include my two principals. Is that because you didn't think they --

CHAIR McCLELLAN: Sorry, remind me of them.

DR. HOPKINS: So I mean just to

save a bunch of time and effort that may occur if it's just a wild west situation. I was just suggesting that you know, all in providers.

CHAIR McCLELLAN: Oh, right.

DR. HOPKINS: Remember that one?

CHAIR McCLELLAN: Yes.

DR. HOPKINS: And best -- based on episodes of care.

CHAIR McCLELLAN: Yes. So, so --

DR. HOPKINS: It could be useful to consumers. It seems like we don't need to take polls of consumers to figure out that that's what they really need.

CHAIR McCLELLAN: Yes, I guess where I did actually mean to -- and I'm sorry if I wasn't explicit. I did mean to incorporate that. And I was in my formulation. And I think Beth picked up on this too.

We focused on starting with relatively simple things like you know, going

to a lab, or going to get an imaging procedure. Or relatively simple and well understood bundles like delivery, you know, uncomplicated delivery. And hip or knee procedure, the so called shoppable conditions.

Bundles for other things may be. I'm not sure there's even a good way to formulate it there. As we talked about yesterday, some challenges with some of those bundles.

But I think the principal applies. I thought you were going to raise something else too around, it seems like the big focus here's understandably been on prices to consumers. But several of you have also made the point about well, there's a sort of complimentary piece and that's to the third party payer, the purchaser, or something like that.

DR. HOPKINS: Yes, but that too, I'm not sure what we can add here. I think that that's a discussion that's been occurring

and will continue to occur between the purchasers and the payers.

But it feels like we're making progress. And yet there are those nagging contractual provisions that exist in some places that prevent the plan from divulging prices to the purchaser. And that's an issue, but I don't think it's an issue to be solved here.

CHAIR McCLELLAN: Were you going to say something?

MS. HIGGINS: No, I was just you know, agreeing with David, yes so.

CHAIR McCLELLAN: Helen?

MS. HASKELL: No, I mean I just think the goal should be to shed as much light as possible. And it's not just people looking for where to have their colonoscopy.

You're talking about researchers and reporters and all sorts of people who can use this information and make it more translatable to consumers.

CHAIR McCLELLAN: Well okay, well I should -- yes, we'll work on how to exactly formulate that. But I should have prefaced everything I said by you know, us making a strong statement that transparency is really important -- transparency around pricing is really important.

And that we should be aiming for that to be as comprehensive as possible you know, given the various constraints we've discussed.

MS. HASKELL: I mean I'm just looking at the Minnesota site and I can't figure out what they mean by cost. Whether it's the cost to the purchaser. I'm just not sure what they mean.

CHAIR McCLELLAN: You want to take that?

COURT REPORTER: I'm sorry ma'am, could you turn on your microphone.

DR. AVERBECK: There we go. It's the average cost across multiple insurance

plans.

COURT REPORTER: I'm sorry ma'am can you also turn your microphone on.

MS. HASKELL: I turned it off so hers would work. So anyway, I'm just saying it's not easy. It's not clear to me if it's the cost to the patient or the cost to the health plan.

DR. AVERBECK: I think it's the average cost across the health plans. So it's not necessarily the price, yes.

CHAIR McCLELLAN: And we're talking about sort of two categories of measures. One is this kind of average price or spend measure. And then the other is the structural measure for how well we're doing on making that relevant, very personalized information available to specific consumers with the main emphasis there being on what plans are doing. And making that available.

MS. HIGGINS: Yes. Two things. One is I think in the summary we should -- I

hope we'll say something about some of the issues that were raised in the HFMA report around anti-competitive impacts.

CHAIR McCLELLAN: Right. Right, and around how transparency is -- they had a nice discussion around the importance of transparency, but some cautions about transparency in certain areas and ways.

MS. HIGGINS: Yes and how that could actually have the opposite effect. And I think in terms of you know we talked about all inclusive, and you know again, something that we discussed at length at the HFMA report, I mean to make prices available and Kevin raised this earlier.

It's not just what plans are doing, it's also what you know, if you're uninsured or self insured, you know what are you going to pay. As well as people who are insured who go out of network and you know the plan has no way of knowing what the price is going to be.

And so I think it has to be all in and not just for services. But everyone you know, who supplies care essentially.

CHAIR McCLELLAN: Okay, so when you say all in, and this is back to David's point too. So these two categories of measures, there's the Minnesota total cost of care concept for getting at something like overall pricing. And that's more by -- more relevant I think by provider actually.

And then there's the personalized information for individuals in plans. For the latter, can you say a little bit more about how you'd make that all in.

And then I do want to -- after that I to push you even harder on the questions that you guys are asking of the plans. And whether you know, how good do you think that is as a way of assessing what's helping us understand what's going on out there.

MS. HIGGINS: Well, yes I think we

did the survey not to develop a measure, just to kind of understand what the industry is doing in this area. So I don't know how it would lend itself to any kind of measurement.

So in terms of you know, the discussion we had as part of the HFMA task force was to say okay, for people who are have insurance, you know the plans a great source. If you're within you know, in network or you know going to participating providers.

But even for those individuals, if they're going to out of network providers, the plan doesn't have -- you know they don't contract with them. So they don't know what rates the providers are going to charge for any specific service or procedure.

So the report actually talks about well then it's really the provider's obligation to give that information to the patient. Especially for shoppable conditions.

And then likewise for people who are you know, uninsured. And you know,

they're going to be looking for information. We actually had someone on the task force who was self insured. A woman who went shopping for you know, her maternity care. Went to hospitals, visited them, tried to get price information.

So you know, it was really interesting to hear her experience and how difficult it was for her to try and get it. And one of the things she said was it would be really helpful if from the public side, Medicare you know, could make available this kind of information so that at least they would have a sense of where to begin.

To say okay, if I'm shopping for this kind of service, maybe maternity's not a good example for Medicare. But you know, hip and knee replacement could be. They could kind of see what Medicare is paying, and that could be a starting point for discussion between the individual who's seeking care and buying care, you know and the provider.

CHAIR McCLELLAN: Do you want to say something on this? Yes.

MS. FOSTER: Medicare has made that available since I don't know, Mark McClellan was the administrator. But it isn't particularly helpful because people don't know it's there and it's very complex.

CHAIR McCLELLAN: Yes the DRG list, the CPT, all that's available.

MS. HIGGINS: And I think it -- yes, it's hard. And I think it's back for her kind of finding in a format that's easy to use.

CHAIR McCLELLAN: Yes, kind of rolled up to something more.

MS. HIGGINS: So as a consumer she can understand it. So I think there's two issue. One is just, is the information available. And then is it available in a way that the consumer can actually use it.

CHAIR McCLELLAN: Well if -- and the thing, so I mean that in principal

wouldn't be that hard. I mean if there are you know kind of relatively standard ways of presenting prices for these shoppable conditions.

And you could think about rolling up the you know, sort of the Medicare charge, you know, the Medicare payment list in the same way. And that would kind of fit with our focus on starting with you know, good information being available on shoppable conditions.

Kevin?

DR. LARSEN: Yes, we haven't really talked about what we -- where we think the idea sort of location of measurement is. We've talked around it a little bit.

I think one opportunity we have is the all-payer claims databases. Certainly not all states have those, but many states have those.

It's a -- that gives a unique opportunity for how to do this kind of multi-

plan measurement that could be aggregated and not like highlight which plan it is, but just for say on the whole.

And so I think the state is going to often be a good unit of measurement in this place for different you know, reasons of state markets and APCDs, et cetera. I don't know if others have other thoughts.

I also thought about the exchanges and the way that we're already doing some -- we're promoting some consumer choice in the exchanges through the measures in the gold star ratings and stuff in the exchanges. And I don't know if that's the right answer or not.

But we haven't really directed our conversation about where we think the price measurement -- the location, the locus of measurement should be.

CHAIR McCLELLAN: That may be a role for states too. We did talk about roll for plans. And some at least for the TCC type

-- total cost of care type measures for providers.

Were you going to say something, or?

DR. AVERBECK: I think I would just comment that this was in Minnesota, it was a start. And so the average price, kind of the menu option and the shoppable conditions then balanced with the total cost of care metric.

And so we think that the information will be richer using both. And not necessarily one or the other exclusively.

CHAIR McCLELLAN: Yes, that' makes sense. Okay. David?

DR. HOPKINS: Let me just go straight to my point about all in and episode based. Think of maternity. It's a simple, shoppable, one of the areas that pops out immediately as amenable to this approach.

If you don't -- if you don't capture the prospective cost of not only the

hospital but the OB and any other processionals that are involved and their fees. If you don't capture what hospitals charge for their nurseries. And especially if they end up in NICUs, you're not giving the perspective patient all the information they need.

So even something as simple as maternity is calling for an episode based approach. And an all in approach. That to me illustrates this point.

CHAIR McCLELLAN: Yes. We -- I think there's agreement about that. And I think that fits with this notion of starting with simple, discrete procedures like imaging or labs going to kind of well under -- well understood episodes like maternity where there is some you know, good work out there on how you roll all that up together.

There's still a lot of the rest of healthcare that doesn't you know, fit in with that yet. But it does provide a -- kind of a

good framework for moving forward.

All right, so I'm not sure if you've got. Do you have something else Kevin, or is that?

Okay. So I'm not sure if you all have what you need, but I feel like between sort of the you know, the statement that transparency's valuable with the qualifications analogous to what some of the HFMA report -- a lots drawn from the HFMA report.

And the goal of applying the Hopkins' principal of all in from a patient standpoint. There is a lot going on around transparency and that we think there may be a couple of areas at least where we should push towards measures, even if we don't have them now.

One is in the -- along something -- something along the lines of the Minnesota total cost of care measure. So Beth will follow up with you about getting details in on

that. On how that best captures sort of average price differences across providers.

And then a second on potential structural measures about whether -- how well consumers are able to get something that meets a definition of transparency from their plans. Maybe from the states, picking up on Kevin's point.

I -- as Aparna said, it's not clear that even how we measure that is well specified. But Aparna if we could maybe start with some of the survey work that AHIPs doing. It's like illustrations of what's going on to try to assess how much transparency is out there. That might be helpful.

MS. HIGGINS: Yes, and I think just you know, like I said, we've done some pre-work before developing the instrument, so we can talk off line about what we found based on that as well, yes.

CHAIR McCLELLAN: Great, great. Okay. So that brings us to Care Coordination.

All right. So with Care Coordination, this is a different situation, so there are a number of preliminary measures for the family here that came from the staff review and that got some positive feedback from the task force. So quite different.

And I'm not sure what page we're on if you're following along in your guide. 31? Okay. So go to page 31 is you want to see what's on the screen right in front of you.

But here there a number of preliminary family measures. And Rob, do you want to go through these?

MR. SAUNDERS: Sure. I think just one sort of background comment on this, is just to note that last -- last year, there was a report on previous families and measures that looked specifically at care coordination measures.

So we actually do have a MAP family of measures about care coordination on

which there are some great measures that we can think about. And what we hope for this group is to really think about well where does that impact Affordability.

So not just are there good measures about care coordination, but were are the top priority you know, possibilities for care coordination measures that can help with affordability.

And I think we touched on a lot of those yesterday when we talked in our breakout groups. I heard at least -- my hearing in the breakout groups, here were discussions about care coordination among each of the three. But that's at least a starting place here.

And then as far as the specific measures we looked at. What we seemed to have heard was that there's more of a focus on outcome measures from care coordination.

And by outcomes I mean looking at things readmissions or hospitalizations as opposed to specific structural measures.

Because there was at least a closer linkage because some of the outcomes of care coordination to affordability as opposed to some of the very specific care coordination measures, like did a mediation record transmit between providers. Or at discharge, did XYZ information move on, because there was a lot longer trail.

And it looks like from our survey that we go two measures that received some type of support from the task force. And then four measures where there was sort of mixed response from the task force. And that's where we are.

Some of these are relatively well know, like the All-Cause on planed hospital readmission measure. Which has received a significant interest -- interest both good and bad. And others.

So I think I'll stop there.

CHAIR McCLELLAN: Okay, so I think are we -- can we go forward to our question

list? So any thoughts about the preliminary measures being proposed for the -- on coordination of care for the affordability family? And any suggestions for either specific additions, or directional comment, or the like? Much as we've done in other areas.

Yes, Nancy go ahead.

MS. FOSTER: Sure, I'd be glad to start. And I guess in our conversations with hospital leaders, the hospital wide all-cause on planned readmissions measure has value.

But maybe at this point in our learning, not as much value as the condition specific measures in helping us to understand what are the underlying impediments to patients being able to continue on their path towards wellness without returning to us. Because the underlying causes seem to vary distinctly between surgical cases and medical cases and so forth.

So having just the single all-cause on planned readmission measure bothers

me a little bit in the top choice. I'd like to have a sort of a more robust selection of condition specific readmission measures so that you can really begin to drill down and understand what coordinations are failing.

CHAIR McCLELLAN: Okay, Gerri?

DR. LAMB: Just a little bit of context first. Because we talked a lot about utilization yesterday as well as cost. And there's a lot of connects between those discussions and what's going on in terms of measurement of care coordination from the vantage point that Rob was talking about, with the implications for affordability.

And just to provide a little bit of that context is like Aparna was saying with the price measures, the same thing is true of care coordination, which is it's in its infancy. And the definition is moving right now as well as a lot of the domains of care coordination.

And utilization is actually one of

the proposed domains. But in terms of leverage, that utilization is being looked at much more broadly then we've been talking here in terms of over utilization.

It's more in terms of the fit between what the consumer needs and how that service package is configured. And so I think there's a lot of opportunity here to look at a broader array of outcome measures.

Readmissions certainly -- it's so big bang right now. And I think Nancy's points are very well taken. Although in the care coordination measurement area, really moving away from condition specific, more towards all-cause.

But one of the other areas that's being looked at I think very closely, is the whole primary care community connect. And what the price tags are associated with that in terms of the best package of acute care versus community based care and how we measure that.

And right now you can see, we don't have any measures about that. And that's the big drive right now. So I guess my thought is the unplanned readmissions, I can understand Nancy's comment about condition specific. And I would look in terms of the discussion yesterday of the big bang areas, cancer, end of life and so forth.

But also look more broadly at the utilization, or maybe the balance between acute care, primary care and community based services. And really have a broad view, post acute, but also the non-traditional services.

CHAIR McCLELLAN: Is there a different measure that might better capture that, even if it's not well formulated now? I mean something that we could talk about directionally?

DR. LAMB: Mark you're talking about the balance between?

CHAIR McCLELLAN: Yes.

DR. LAMB: I'm trying to remember

if any came forward. I don't believe so. I think most of the measures right now are readmission measures. Rob, do you have?

MR. SAUNDERS: That sounds accurate for it.

DR. LAMB: I don't think there are any that are really looking at the pro use of community based services versus keeping them out of the hospital when they don't belong there.

CHAIR McCLELLAN: Yes. David?

DR. HOPKINS: I think you know, this is the best starting point. And I'm happy if Nancy's point you know, to move the measures on the right back over to the left, that are more specific on readmissions.

But at the same time, I can't help but note that our focus on hospital readmission is looking at the ultimate failure of care coordination. And when are we -- so one again, we're back into a gap discussion obviously. Because we don't have these

measures today.

But when you think about all the hand offs that occur in healthcare, and it isn't just you know, physician to hospital, it's physician to physician. And group to group. And so on and so forth.

Is there some way we can think of to identify where that's being done -- where those hand offs are being done right. And I know Kevin's thought about this because there's a whole question about what information gets transferred, and can you make that happen.

I just hope that we can get beyond looking at a hospital readmission as the only focus of care coordination. It's the ultimate failure. So much more to do be done to prevent that.

CHAIR McCLELLAN: Thanks. Helen?

MS. HASKELL: Well in a lot of ways I'm just echoing that. But I think that there's too much focus on the discharge from

hospitals and care coordination.

And Kevin, I'd be really interested to hear what you think is available. But not only hand offs within hospitals, but communication between doctors in the community. All of these critical areas that fall down on a regular basis. And is there a way to measure it, and who owns it?

DR. LARSEN: So I can take that. I'm again lucky enough in my role in federal government to actually have some contracts to be building measures of care coordination.

And we are really hoping to do these same things. We have really terrific top notch measure developer, funded, doing research, trying to figure this out. And one of the challenges in the measure development life cycle, is you have to measure when it's going well, and be able to say that your measure actually measures what you think it measures.

And we have struggled and

struggled to find prototypes of where there is fantastic care coordination with really good interconnection of all the technologies in a way that we can actually go in and show that our measure measures what it is we want to have measured.

There's a lot of terrific frame works for how this works. And some examples within a single integrated health system, so I could potentially go into Kaiser and build a measure that says okay, in Kaiser this what good care coordination looks like. But we need something that would be scalable outside of one single system.

So we're trying and we're working hard with groups that have regional health information exchanges and have pilots of many different types. Some of the things that we've looked at are, can we -- can standardized documents around care plans for example, be moved reliably and routinely from site to site. And are people using them and

seeing them?

For a year of looking, we haven't found a community that we think that's happening in with enough scale that we can validate and measure. So if anyone has ideas about where we can go, that this is really working here, and I'll send my people there, and we will be sure that the measures we have in our cue, can be tested so that they could eventually come through NQF for endorsement.

CHAIR McCLELLAN: Well I mean that is where some of the meaningful use measures are intended to head. I mean you're right, you're not there yet. But that doesn't mean we can't say something directionally about look, we need measures of key information actually flowing on a large routine basis between providers. I mean that seems.

DR. LARSEN: Yes absolutely. And I there are a couple of I think key opportunities here. So one is the CARE tool and many of you may have been paying attention

to that. There's another thing called the impact tool. They're standardized data tools that CMS has been promoting for the sharing of consistent information site to site.

They're not dependent on technology, but could be enable to technology. What we've been working on are what are called continuity of care documents. Which are electronic documents that are required under meaningful use to move site to site.

We're testing right now. Care coordination measure that did that continuity of care document make it from site A to site B. But people aren't really that excited about just did the paperwork move.

But let me tell you, it's even a struggle for us to test that. So we're with you, and we're working hard, but we need help.

CHAIR McCLELLAN: Okay. Thanks and that brought some more cards up too. Next I have Jennifer.

DR. THOMAS: So one of the

measures that we discussed yesterday's still on the wall. But 0554, which is the medication reconciliation post discharge. Again you know, focusing on the discharge or the post-discharge folks.

That I think the intent of that measure was to get at some of this and the coordination of medication issues. Because at least in the draft of the national plan for ADE prevention, we know that background data is that about three and a half million folks are seeing the physician because of adverse drug events every year.

A million, or almost a million ER visits, et cetera. So I think that was one of the measures that was aligned with star boost and Coleman model. Whatever model we're using for care transitions to touch base on medication use.

CHAIR McCLELLAN: Thank you. David?

DR. SEIDENWURM: Well, two things.

Just to make a suggestion. The -- and I don't want to talk up the competition or anything, but Northern California Kaiser Hypertension program might be you know, a model of care coordination. And so if there were a way to -- if you can't measure that, then maybe we can't measure anything. So that might be a stereotype one.

The thing is, I think that maybe one of the things that we could do in this group to improve things with the respect to care coordination, is to distinguish among the possibility of communication between -- or among economically related and economically unrelated entities.

Because the market will take care of communication when there's an economic interest and when there's a business model for the communication to occur.

You know, in a system like the one in which I work now, there are enormous incentives to communicate up and down the

system to coordinate referrals, keep people out of the hospital, you now open an urgent care clinic, coordinate with the pharmacies. You know bring the people from Walmart to the hospital to counsel the patients.

All kinds of stuff like that. You know, not a problem. The problem is in the fragmented part of the system, which I was in until a couple of months ago, when -- there's no business case for the communication.

And so we wrote -- we wrote a performance metric for this, for exchange of radiology information. We just did CT because that was the high radiation exposure procedure. And it was under the rubric of irradiation exposure one.

And so you know, we divided it into two parts. You know, one was you know, when you do a CT, you put that information, you know, the images and the report out into the -- into this place were this non-economically related entity could get to it.

And then the other was every time you did a CT, you looked for someone else.

Right, so you know, very small steps. Tiny baby steps, but I wonder if there are some elements in there that could be used? That's in the PCPIOPEIR set.

And I think it's part of a measure group that's part of PQRS. But I don't think that it's come through NQF. And have I used enough initials there?

CHAIR McCLELLAN: Very impressive. Peg?

DR. TERRY: A few things. It's interesting, I was just at a meeting and talking to the Senate Finance staff about the common assessment tool. And I'm familiar with the CARE tool because were I came from we used -- we were the demo.

And so there's a lot of interest in this assessment tool, the CARE tool does go across post acute settings, but was originally tested at the hospital as well. So it is a

way to look at a patient and even look at outcomes in quality outcomes based on their movement through the system.

And they're interested also in CMS, and sort of the financial part of this. So how does this work when they move through the system. And you know, how are they doing on their functional test, how are they doing on their self care? Whatever they're measuring.

I think it's -- those are beginning measures, but I think those are some important measures. As to the inter-connectivity issue, you know when you're in the community, it doesn't really exist very well. And everybody's trying to make it work.

And so I know in Worcester, Mass, I don't know if you're familiar with what's going on there, but -- I think it's Atrius, is that the name of it?

CHAIR McCLELLAN: Atrius?

DR. TERRY: Atrius, yes, the

physician group. They as well as others have been really involved in trying to connect both the community setting, home care setting and others with the physician practice. And they have ONC money to do this. They've been working on it. I don't' think they've quite made it work yet, but I think they're almost there.

So may -- I'm sure you're very ware of it, but it may be worth looking at how they're able sort of to connect what's going on with a patient, and all the alerts that are part of this. You know, patient goes in the hospital, alert. You know, that kind of thing.

As well as KeyHIE in Pennsylvania, has really been working with both the post-acute sector as well as the hospital SNF sector looking at you know, how to alert different providers. It's not giving enough information, I think the Massachusetts one is probably more rich in data.

But all I can say is they have to figure out a way -- somebody in the government has to support -- I'm looking at you of course as you're -- how to -- how to really -- because unless you have good, good records, good information that's going timely, it's all about timeliness to really do care coordination. It's truly not going to work enough beyond the hospital setting and maybe physician setting.

CHAIR McCLELLAN: Can I follow up on your comment on the CARE tool and the common assessment tool. Is there a measure based on that that you have in mind. Or just that's the kind of you know, sort of common assessment information sharing that you want to encourage?

DR. TERRY: You know -- you know thinking about what would be the way to measure the effectiveness of a tool and what would be the numerator and denominator I guess, I have -- let me think about that. I

mean I think there is a lot to be said about frankly that tool.

And it's not perfect. I mean everybody knows it's not perfect. But it does begin to kind of sort and look at patients as they move through the system. And there is -- you can put an affordability piece to it.

So you know, if they're going -- and that's sort of where they're going. If you go to a you know, you're in the hospital and it costs this much. And then you go to a SNF or an inpatient rehab facility, you know, what are you -- and they're beginning to in the report, they had a report.

I don't know -- I'm sure some people are aware of it. That went to CMS and they really tried to capture the cost of some of this as patients moved through the system. So it is what are the measures?

What are your -- and I'm not sure those are the best measures, but what are the -- you know, what are the quality outcomes

based on you know, the -- I guess the cost incurred as you're moving through the system.

And you know they were trying to come up with eventually a way to use it for placement. So I just -- I have to think about how to put that into an affordability. But there are -- there are issues I guess mostly in the post-acute sector.

But I think it may be -- I don't think it's been used in physician practices, but I do think --

CHAIR McCLELLAN: Well, I mean it does include you know some outcome assessment or functional status assessment, and that is what CARE coordination is useful for and intended to help improvement. And whereas functional status declines mean higher costs too, so.

DR. TERRY: Right, it was a very -- their initial -- their work was very impressive in looking across a setting and how people were doing functionally as well in

their self care ability to take care of themselves, take their meds, all that, so.

CHAIR McCLELLAN: Joanne?

DR. CONROY: So I have a visceral response to the CARE tool and this is the reason why.

CHAIR McCLELLAN: It sounds like not a good visceral response.

DR. CONROY: We have had a number of conversations with CMS. It's not a bad -- it's not a bad tool. It's long. It's like 25 pages. And you're asking people to do it at least three times within a patient's stay.

They're asking all the bundlers to do it. It is not integrated in the EMR. Please do not ask anybody to something that is not integrated into the EMR. And CMS has been resistant to doing that.

We've had the OMC involved and everything. It's a great tool, but I can tell you that there would be an outcry and probably to insisting that we use this as some type of

metric.

Now I did pull out the ACO care coordination metrics. And I like to think that we kind of try to use metrics we're currently using.

They do have the risk standardized all-condition readmission. They have a couple of ambulatory sensitive conditions, COPD and congestive heart failure. They do have the percent of primary care physicians who successfully qualify for EHR program incentive payment.

I wonder if that could be actually morphed into some assessment of whether or not they actually have access to the rest of the records required for care coordination. There's the Medrec, Jennifer, and then there's screening for falls risk.

So it would be nice if we decided to support a metric, that it would be something that would already be maybe in the bucket, the ACOs and maybe the bundlers are

going to be used.

DR. LARSEN: And this is Kevin, just a quick clarification. You're talking about the B-CARE tool, which is a version of the CARE tool that's included I think in MSSP. It's one of the ACO programs.

So CMS does require it in some programs now through this B-CARE option. And that's the specific portion, they're also thinking about it, CMS, more broadly across a number of other programs, not just the MSSP.

DR. CONROY: Yes, all the bundlers, and you know they're -- that affects a lot of people. There are probably more people in bundling then there are in MSSP now.

CHAIR McCLELLAN: Just a follow up on the ACO suggestion. So some of those -- you know some of them are similar to the readmission measures already on the list.

And there are a couple of ambulatory sensitive conditions, COPD, CHF, which are not so hot -- is 171, is that

related to -- NQF 171, the acute care admission?

Okay, so acute care hospitalization from post-acute. So that starts to get at the post-acute care coordination side. But these other ambulatory sensitive condition measures. Are those not endorsed?

I guess I'm talking about the ACO, the Medicare ACO.

MR. SANCHEZ: We can pull those up.

CHAIR McCLELLAN: Yes, well those might start getting at some of these ambulatory care.

DR. HOPKINS: Like admissions for CHF, right?

CHAIR McCLELLAN: Yes.

DR. HOPKINS: We should end it.

C We're talking about it. CHF and COPD, okay.

UNKNOWN: Asthma too, I think was

there. We looked at these yesterday in utilization.

CHAIR McCLELLAN: Okay. Nancy?

MS. FOSTER: Thanks Mark. I wanted to suggest sort of two newer areas for which I don't believe there are measures yet, but really are vital in some of the work that's going on around care coordination.

One is I'd like to think about how we get a better view of the effective use of telemedicine, and it's ability to support people in lower cost settings. We know it's true in helping to prevent readmissions.

But I'd like to think about how we can look at some of the others who are using it even more effectively for some other conditions. Including as I'm understanding now, some place is beginning to use it to support pregnant women so that they -- or new moms so they're not rushing to the ER with every little nick.

The second thing, not that I've

heard of anybody using this yet, but really the discussion our small group had yesterday around hospice care, makes me wonder if there's an opportunity here to think about how could we define and then measure affective preparation for end of life care.

You know, what's the coordination between the primary care physician, whether that is an oncologist or cardiologist or a primary are physician. And the patient and the patient family, and how do we get around that?

Because the measure we chose yesterday, about three days stay in hospice, just doesn't really, I know it's important. That's pushing at it from one end. I'd like to see how we could push at it from the other end. What's that effective care coordination look like as people approach the end of life?

CHAIR McCLELLAN: Very good question. Beth?

DR. AVERBECK: Just wanted to

raise, we are in Minnesota, we're piloting a measure right now. And it's a post-hospital discharge.

And originally the conversation started out of an office visit within seven days. And then there was enough conversation in the community that might add cost if we could do it by phone.

And so the measure does look at post-discharge for heart failure, pneumonia, ischemic vascular disease and COPD. And did they either have telephone contact, an e-contact within three days, or an office visit within seven.

So it's early on, it's in pilot. But we are starting to try and look at what kind of a measure that might be for the community.

CHAIR McCLELLAN: Thanks. Jim?

DR. DUNFORD: Oh, and I just wanted to talk a little bit more about the idea of the value of alerting, which I think

is really just in it's infancy, in terms of automatic electronic health record alerting for full range of different providers.

Readmissions being a classic one of alerting cardiac teams to the emergency department upon entrance has been shown to facilitate you know, reductions in admissions.

In my community we have a system that just got AHRQ. We'll be on the innovation exchange as a best practice next month. We have the paramedics alerting on case manager -- on case managed patients.

So we can actually by the time -- in the livingroom of a house, we have case records of individuals who have agreed to share their information with the fire department and paramedics. And if we go to their homes and they are known to be frequent users, then we can push alerts to their care coordinators before we ever get to the emergency department.

And the goal would be to actually

not even take those people to the emergency department if that's not really the best place for them to go. But the use of ADT feeds, the admission discharge transfer, which is an alert that occurs at the hospital registration moment, which was used in Camden to great success.

The Camden collaborative uses an ADT feed for Jeff Brenner to be able to reduce readmissions. And all those alerting mechanisms are really invaluable electronic health record things that could be measured.

You know the frequency with which people got an ADT feed within 24 hours of knowledge of their patient being admitted to hospital for example. Or even earlier on to be able to prevent the admission in the first place.

CHAIR McCLELLAN: Is there a -- is there a good metric based on that?

DR. LARSEN: Yes, this Kevin. I can take that. So the ADT feeds for those

familiar, Admission, Discharge and Transfer, it's the routine hospital administration information that says this person was in the hospital.

A big portion of our ONC Health IT activity is to stand up what are called regional health information exchanges, which are -- are typically often in a state. Some states have many of them, that interconnect lots of different providers.

And one of the things that has become an early and important value that they add is that the hospitals will feed their admission messaging into that. And then primary care providers and others can sign up to get a real time alert when their patient has been admitted to the hospital, or in some states, also has gone to the ER.

Some places like Rhode Island and Maryland, these are really wide spread. Other places they've been kind of just starting, but we do have a measure of how often that's

going, how often those feeds are occurring.

And we know from the states where this has happened that there's been incredible, positive benefit for the patients as well as the coordination by providers. So that's something that we do measure at ONC, typically through these health information exchanges.

CHAIR McCLELLAN: So this can be a regional or state level measure and it's something that ONC has now?

DR. LARSEN: Correct. We don't think of it as a quality measure right now, but we could. It's right now a measure of health information exchange adoption.

So, but it's the kind of thing that could become a measure of quality.

DR. DUNFORD: Could I follow up on that? Just to give you an idea where the pre-hospital world is going, last night, the Tulsa Fire Department announced that they were going to be taking a comprehensive look at

everything they do. Because over 90 percent of what they do is actually medical care, it's not fire.

And so looking particularly at the frequent user. The frequent user of emergency departments all around the United States, you're seeing Fire Chiefs re-purposing themselves to be able to do more. To take care of the chronically ill person who increasingly becomes the burden of their system.

And the idea of alerting becomes a really, an attractive tool and service that they can provide. Not only fall prevention and all the other typical things, but the idea of early notification systems. Because almost all of your high performance EMS systems have electronic health records these days.

We were one of the beacons. San Diego's beacon actually, I was one of the leads on that, was in terms of EMS linkage. So where you're seeing a lot of this moving is

the idea of bi-directional electronic information exchange between out of hospital providers and hospitals and exchanges.

So the notion of being able to more again, visiting home nurse services obviously being a great example, but there's a growing notion of something called the community paramedic, who could actually do some very you know, low level, but competent things because they're already in that community.

And notion Kevin and I were talking about meaningful use incentivization to be able to enhance the ability of exchanges and hospitals to actually share information in that world. All of this ability to alert you and say hey, your high use, high need patient has just called again for the 50th time. What would you like to do today.

We've used this in success. We've created a program called Project 25. And San Diego was the 25 most impactful people in the

city. And we dramatically drove down cost to the millions of dollars in real costs over three years by housing them and providing these kinds of alerting services.

CHAIR McCLELLAN: Thanks. Aparna?

MS. HIGGINS: So maybe this belongs more in the gap discussion, but I was struck by kind of what David said earlier, actually both Davids and Kevin.

CHAIR McCLELLAN: We are having the gap discussion.

MS. HIGGINS: So -- but you know as to readmissions being the -- sort of the ultimate failure. And I wondering if maybe you know one of the things we want to say in the report is what we need are good system level measures of defects. Which I don't think that we have in healthcare.

We have readmissions, we have maybe ED visits, and you know, maybe falls. But a much more systematic way of measuring defects. And you know, similar to how Toyota

does it for example.

And then coupled with that, of the other David's point, about having the business model that will make people focus on those defects and getting rid of processes and involving processes that will help elimination of those defects.

Which is kind of a different approach to I think thinking about this. As much as it's important to find good examples of where -- or maybe this where I might disagree a little bit with you Kevin, of where good care coordination is taking place.

Once you kind of build a measure around it and kind of bake it in, I fear that that becomes the only model, and I think we want a thousand flowers to bloom relative to process.

CHAIR McCLELLAN: We certainly aren't happy with the models we have now.

MS. HIGGINS: Exactly. And you know, and I think you know, we've had a lot of

discussion or innovation when we were talking about prices. And I think in the same way you know we want innovation on how health care is delivered.

And so I'm sure you know, that's what the ONC is trying to support. So I think that there's a fine line between trying to focus a lot on process measures, but at the same time I feel like having a strategy and a good one around measuring defects in healthcare is going to get us a long way.

CHAIR McCLELLAN: So any more specific --

MS. HIGGINS: I don't have specific suggestions unfortunately. Like I said you know, I mean the ready examples are readmissions and ED visits. But I know we talk about measuring safety and adverse events. You know those might be other areas as well.

But I think you know this requires more thinking then this meeting allows, and

time for more you know, sort of considered thought. But I think that's you know, could be a very useful strategy.

DR. LARSEN: So the policy committee that informs ONC and CMS, about the communities programs has been thinking a lot about this. A number of thoughtful people have said they would think a terrific measure about care coordination would be a patient report measure was your care coordinated.

And that that could be an outcome measure that would really be cross cutting now. There are a lot of methodological questions about that, I mean do they know what they could have, et cetera.

But that would be -- that's one that is appealing outcome oriented. And potentially quickly scaled.

Another one that -- so I'm a part of a person and family centered outcomes measures project here at NQF looking at measure gaps. And we just had testimony there

from a really creative practice in Texas that does a PCMH program.

And they have started measuring convenience. And they call convenience their new measure of quality.

And their idea of convenience is to look at dates of service, and identify when there are too many dates of service for things that should be packaged and bundled on one date of service.

So that's something again you could get out of claims pretty straightforwardly, if someone has ten days of service within a two week period, versus somebody else that all the same activities with two dates of service, you could imagine as a patient which of those two things you would pick.

And so that's another I think interesting, appealing, possible way to use the data that we have. Especially again, with the non-payer claims database. But you could

do this in any number of different ways.

To start to understand where there is not convenient care, which is the reason we're in many ways using coordination, is to try to help people through a very inconveniently organized system.

CHAIR McCLELLAN: Thanks. Peg?

DR. TERRY: You know it's interesting you should say that because I was thinking of the Kaiser Study of hypertension. And one of the things they did is to achieve their results is that they made it more convenient for people to come in and have their blood pressure taken.

And they made the medication easier for the patient to take. So simple -- simple things like that are really the things.

I was really following up on what Nancy was going to say though -- that Nancy was saying. Because we had this spirited conversation yesterday about this issue.

And end of life care does hit that

very high cost area. And I know there are -- there a lot of ways people are trying to improve it. And we're you know, pallative dare teams and hospitals, you know, working with patients, trying to make decisions early.

And I know there are advanced -- advanced care planning measures out there. It is a bit of a tricky issue I think. But I think that if there was some way we could measure how patients -- how early we you know, somebody has a possible prognosis of six month or less, just using the hospice kind of definition.

Some way we could measure you know, how quickly, or measure when these beginning conversations take place, it kind of gives that you know patients knowing more to be able to move into maybe a trajectory that would be better for them.

And so -- and less costly. So I mean instead of a back way of getting at it, and maybe it's a hospital measure. Maybe it's

across the system. I mean maybe it goes to the physician practice or the oncologist practice, or you know whatever. And then beyond that.

Because there is a --there's a growing trend I think to have some form of pallative care kind of outside the hospital. And getting patients to that helps with the transition. And you know there's a demonstration that's been funded out there, a widen -- that whatever for, not a lot of money, but beginning of some kind of hospice, what I call pallative care transition benefit per se in looking at that.

And so I think there is something to be said for that. How to do that. Because I think it is a big affordability issue.

CHAIR McCLELLAN: Thanks. I think end of life care is a great example to highlight for where a leading area for measuring coordination of care.

One other that I just wanted to

mention that we've talked about in passing that came up in comments on the preliminary exercise that you all did was measures of duplicative services of some kind. It kind of strikes me a bit like the multiple date measure that you mentioned before.

I don't think we have any good specific examples of what that would like, but if there any suggestions on flushing that out too, that would be good.

Gerri?

DR. LAMB: Along with the duplicative and Kevin's comment about convenience. Some of the areas that are being looked at in terms of measures gaps, are the whole areas of organization, synchronization, timing of care, because it's so integral to care coordination.

And just simple things like, and there aren't any measures right now in the family for these. But if somebody is high risk and they need certain services to stay in

the home, like oxygen or whatever, does it get delivered in a timely way. And what are the implications of that?

So and that's very costly in terms of the readmissions and the low hanging fruit we have here. The other thought is I think we're all saying that the readmission is kind of an obvious one in terms of cost.

But it might be useful to go back to the family of care coordination measures with another eye towards what are the cost implications of that. Because there are some in the family related to not just Medrec, but discrepancies in medication between hospital discharge and home that have cost implications to them.

So maybe going back to some of the ones that are already endorsed with a broader view might be really useful. And as well as going back to, or looking at the report for the measures gaps that's coming out next month related to the recommendations for new

domains.

And utilization is one of those domains. A plan of care that is regularly reevaluated is another one. And some of the outcomes that everybody's been talking about are also on there.

CHAIR McCLELLAN: Great. Thanks. Joanne?

DR. CONROY: So David can probably answer this better, but I think the areas that at least from a hospital perspective, we see most of the duplication of services is in imaging and lab. And that actually could be something we could probably create a measure around and then have it tested.

And the second thing I was just considering Kevin's point about how coordinated the services are versus kind of how long they're also spread over a you know what duration? You know we did an analysis of high utilizers that usually have a dual diagnosis of pain management and a behavior

health diagnosis. And they usually are your super, super, super high utilizers.

I guess I'm going to bring up the third rail. There is a social determinate of health piece to that. And I just -- I know that there's a lot of controversy over how you risk adjust this group.

So I just put that out there that that would be another variable we'd probably have to consider. But that would be a way that we actually identify how you would coordinate that care. And that probably would be an improvement measure rather than an absolute measure, so.

CHAIR McCLELLAN: David?

DR. SEIDENWURM: Well, yes I was going to get to that issue, so thank you for the intro. Okay, there are some performance metrics in play that get at this repeat service piece. And you know, I'm not sure that they're exactly the right ones, but they could certainly be prototypes for future

measure development.

There's a lumbar spine and low back pain repeat imaging measure that's been put into a process. And I don't know whether it's timed out or you know, what status it's in. So we could look at that.

There are stereotype clinical situations where we know that a proportion of patients need follow up, but we you know, we don't' want to there to be too many, and we don't want there to be too few.

And so we know that there's the Hopes measure for mammography recall, which is based purely on administrative date. I think it's not perfect, but I think it's pretty darn good. So that could be a prototype for looking at repeat you know, anything in other circumstances.

Also, you know it could be repeat procedures of various sorts, knee injections or something you know for pain, or shoulder injection for pain or something. There's --

we have a reminder system for a mammography measure that has been NQF endorsed.

You know, it's agnostic as to the frequency of mammography and the age of starting and whatever. But once you're in the system, you know, you should be enrolled in a reminder system so you complete the process.

There's joint commission work on critical values reporting that go to coordination of care. And I think that we can use some of those definitions for you know, documenting two way communication in various ways.

And I believe that there's an electronic component to that. And also a you know, a telephone you know, or carrier pigeon. I mean it's completely agnostic as to the mode of communication.

And then there ought to be both a business case and a medical case and a convenience case, so a patient centered case for repeat imaging of certain sorts. Because

there's a new -- or not so new anymore, a couple of years old -- contiguous body part rule in Medicare for imaging.

That there's a different way things are charged if you, you know image contiguous body parts on the same day. So there would be -- I would image there would be a budget case for measuring that. And looking at that.

So I think that if you looked at those as models, you could come up with you know, people who know more about different you know, areas of clinical care. Could look at ways of you know, looking at duplicative services and comparing you know, what the lower and upper bounds of acceptable rates might be for these things.

And if nothing else, benchmarking. And I think some of the structure of those measures are in the -- you know are in our domain here.

CHAIR McCLELLAN: Right. Okay, so

staff may need to follow up with you about a couple of those specific ones, but thanks for the very helpful list.

So just looking at the time, I think it's about time to wrap this up. Kevin, go ahead.

DR. LARSEN: Just a quick thing about the social determinants of health. So there's currently an IOM committee looking at which social determinants of health could be or should be used to be routinely collected for electronic health records.

And where they have a preliminary report that's out now. And that may subsequently come out.

What I'll say in the person centered care work in talking to a lot of organizations that do these various HotSpot programs. Most of them are not focusing on the risk adjustment, but rather again a convenience and market segmentation approach. So if you talk to -- what's his name in

Camden?

He talks about how -- how we need to think about market segmentation just like various commercial retailers do. And think about certain groups like the homeless as a market segment. And we need to do analysis about what their needs and how they interact with the system are, with focus groups and care models arranged around them as a market segment.

And the places that do that have had fantastic success. And I'll just give you a quick example from my home organization. We had a fail rate of like 80 percent of all of our clinic visits before 9:00 a.m.

Well we realize that the city bus system didn't -- you had to pay the high rate for what do you call it, rush hour. And so nobody who was poor wanted to go to the doctor when they had to pay rush rates for the city buses.

And so when we knew that, wall of

a sudden we could really change our expectations about how we scheduled appointments and we were no longer having an 80 percent fail rate in the before 9:00 a.m. Because there was a kind of structural market segment issue with the people living in poverty not wanting to take high cost bus trips to the doctor.

CHAIR McCLELLAN: Okay. This has been a great discussion and a lot more measures to work with here. But clearly some gaps too. So among the things that we'll include in the report is highlighting the work that's been done. And the coordination of care family, specifically looking at measures there that have significant cost implications.

We go back to the measure -- the preliminary measure list, it sounds like people were pretty supportive putting everything on the left and right into our list of recommendations, as well as endorse measures on specific ambulatory sensitive

conditions, such as those in the ACO, I think there may be a few others in the NQF endorsed list as well.

And then in terms of gaps, one that seemed might be relatively easy to fill was looking at some of the ONC measures on availability of information for sharing. Particularly the ADT availability. Jim gave a good case for why that's really useful.

And end care coordination, that's a measure at the regional level, where it seems like it would be most relevant, is it's available now.

In terms of other gaps for the -- to get at you know, addressing these problems before, sort of the ultimate system defect of a hospital admission or readmission. Some promising directions perhaps with the CARE tool, which has a good outcome orientation.

And it's focus on frail, multi-comorbid patients. But it is, there are some obviously a burden in administration --

administratively challenging issues with using it. Particularly it's fit into an EMR.

Encouraging more inter-connectivity beyond the hospital through a systematic approach to measuring defects. I guess that's kind of a more general thing that Aparna brought up, where measures like ED visit rates, some more outcome -- some patient reported measures like patient reports of care coordination, maybe measures of care coordination near the end of life could help.

And we also had some good examples of specific potential measures for duplicative of services, especially around imaging and labs.

Good. Good work guys. So we're schedule to restart at 11:00. If we run a couple of minutes late, let's say 15 minutes, 11:05 for starting again. Okay, thanks.

(Whereupon, the foregoing matter went off the record at 10:47

a.m. and went back on the record at 11:05 a.m.)

CHAIR McCLELLAN: Okay. I know not everybody's back at the table yet, but that never stops me. I want to get done on time, right.

So we're moving on to one further area of measure review. And that's related to errors and complications. And this too was part of the pre-meeting exercise that people completed.

And in this area, I don't know if this was the arrangement, but today we've gone from like no measures that people like to some to more. And here there's a long list of preliminary measures for inclusion. And actually not really much in the way of suggestions, at least pre-meeting from all of you about key measurement gaps.

So I thought we'd spend a minute if Rob will help me going through the measures

that are on the list. And the ones that were preferred, the ones that weren't.

And we can then discuss whether there should be any additions to the list and also any measurement gaps, I think together, since we've got a good start of error measures here.

MS. SAUNDERS: So, just like with care coordination, there's actually an existing MAP family of measures looking at safety. So what the staff did was really start with that list of measures since we don't need to reinvent the wheel. And really look at it through an affordability lense.

And as with care coordination or almost with anything in health care, it all can have an affordability dimension, so we tried to only pull up the ones that had evidence about a large impact on cost of care. And that was what we presented for the homework.

And we had as Mark says, most

people agree with almost all of these safety measures that were put forward. That they saw that these had some level of importance in terms of impacting affordability.

Several of them are well known to you such as catheter associated infection measures, both blood stream and urinary. Looking at some of the foreign bodies left during procedures. Or wrong side surgeries.

Preventable venous thromboembolism, ventilator suction pneumonia, pressure ulcer problems and actually had two pressure ulcer measures, so. Those are sort of the background.

But again the idea was not necessarily looking at what are the most important safety measures, but what are the most important safety measures that we know have an impact on affordability.

So, let me turn that back.

CHAIR McCLELLAN: Okay, so that's the starting list, so if any of you want to

say anything about the measures not selected or if there are any reasons given, or?

MR. SAUNDERS: We didn't get a lot of reasons given. I think in this one there were -- just because there were so many, there were some in the interest of parsimony, there were some that when people ranked, sort of fell toward the end. And these were the three that sort of fell toward the end.

I don't know if there were necessarily strong feelings that these weren't necessarily important, but it was just they ended up at the end of people's piles over time.

CHAIR McCLELLAN: I think parsimony may have figured into that say with pressure ulcers.

David?

DR. HOPKINS: Can you --

CHAIR McCLELLAN: The three pressure ulcer measures, or

DR. HOPKINS: The three not

selected.

CHAIR McCLELLAN: The three not selected, okay.

MR. SAUNDERS: Sure, what level of specification would you like? Sure. No, happy to do it. All right, well then let me pull that up real fast, and --

CHAIR McCLELLAN: Now pressure ulcers, keep in mind that one wasn't selected. There are a couple that were on the priority list that were more related to -- they were more clearly related to direct consequences of healthcare.

MR. SAUNDERS: Sure. So for those three, so 337, the pressure ulcer rate, the numerator is the percent of discharges. Basically among cases where they've done ICD 9 code, about pressure ulcer.

And we are -- I'm sorry, that's just the description. The numerator for that one is again, if you're looking at the discharges, the denominator is really looking

at any sort of surgical or medical discharges.

The patient safety for selected indicators is an ARQH measure. That's a composite measure looking at a potentially, preventable adverse events for the selected indicators in the ARQH warehouse.

And it's a very similar composite indicator for the second one, which is looking at in that ARQH warehouse, what are the ones that are potentially preventable ones for pediatrics. There are a lot of Ps in that one.

So those were those three.

DR. HOPKINS: So I think it sort of points out the classic dilemma because I can see why a lot of us are drawn to the measures on the left that are much more specific.

But for a different kind of audience, these composites really are pretty meaningful. I would like to see them kept on the list.

CHAIR McCLELLAN: Thanks David, okay. Sounds like a lot of head nodding. So is there a preference for the composite measure, or do we need to include both and explain why both may be relevant?

COURT REPORTER: I'm sorry sir, would you turn on your microphone.

DR. HOPKINS: I was just saying yes to both because one audience can use the composite. Another audience needs the specifics. We're all stakeholders that need to do that.

DR. CONROY: Well actually it's a question, and we had a concern that the foreign left during the procedure is such a rare -- hopefully, rare thing. But is that in the composite measure?

CHAIR McCLELLAN: Yes.

DR. CONROY: So would that be something that you might not have the specific that you would still have attention to it in the composite.

MS. FOSTER: So I think my concern about the measures on the right are the actual reliability of the data. These are really not great measures.

CHAIR McCLELLAN: They're infrequent, they're harder.

MS. FOSTER: No, the data sources are bad. The measures themselves are not reliable indicators of actual prevalence of safety events, pressure ulcers. Because it means in order for it to get here it has to appear on a claim. So it has to be recognized, it has to have been recorded in a way that is extractable there are core measures - but if you wanted to talk about broader harm measures, that's an interesting conversation to have.

CHAIR McCLELLAN: Okay, well, so I would definitely like to get to that broader conversation about harm and I think that's where Joanne was going with her confidence measure. There is a lot of specific harms that

we are getting better at identifying, or at least describing each one by itself and not having the impact on cost. David.

(Audio interference)

DR. SEIDENWURM: Well, what I was going to say was that to a practicing clinician, to a hospital, to a consumer, I think the concept is, was the hospital stay safe? And so I was going to speak in favor of the composite metrics. Because I think the idea is, did you get a drivable car? I think we can talk about whether it was the breaks, or whether it was the motor, or whether it was the transmission. But the defect is, was the hospital stay a safe stay. In the stroke work group I participated in, we had avoidable complications (Audio interference)

CHAIR McCLELLAN: So Rob has the definition that Joanne asked about earlier, and then I was going to maybe ask you all, ask you as well. I mean there is some NQF work on -- or NQF endorsed measures related to

competence for conditions like stroke I think, right?

I mean you guys have worked on that. And if there's a way to you know, sort of make that more of the focus of this report, I mean that does seem to fit with the theme of overall cost impact as opposed to a detailed family of measures related to errors and complications.

DR. SEIDENWURM: And the other thing I wanted to say which I forgot, I'm sorry, was if you're going to segment it, I think it might be more clinically meaningful if you segmented it by disease state or something like that, rather or by --

CHAIR McCLELLAN: Rather than by type specific error?

DR. SEIDENWURM: You know, in other words, you know it's more important to know what happened to your stoke patients maybe for a clinical team then how many people got UTIs. You know, because that way --

that's how the department's organized.

CHAIR McCLELLAN: Well that kind of fits with Nancy's comment the last time around of fitting in. That's where the systematic approach is to improving quality and efficiency are going to come in. And where a lot of our measures seem to be headed is towards you know, sort of common clinical conditions.

MR. SAUNDERS: And to join this question, if our correction does not include foreign body lock down. So it's got pressure ulcers, numo-thorax, catheter related infections, hip fracture, this lists a lot of peri-operative issues like hemorrhage, respiratory failure, pulmonary embolism, DBT, sepsis. So but not say that mention of foreign body lock down. Yes, I am talking about 531.

CHAIR McCLELLAN: Did you have something else on this?

DR. CONROY: Yes. Just another

comment. This may belong in the gap discussion, but I mean we've been working with Chuck Kilo from OHSU and they're trying to actually identify environments that are not safe rather than looking at an outcome which may be rare, but disastrous.

Is there a way we an actually assess the safety environment and I think there's some working being done on that, and I think they're getting close to a metric, but I don't actually know where they are.

And it has something to do with the culture of safety, no I don't think that's examined by the ARQH survey. But maybe somebody in the room knows a little bit more about it. But we really want to get a metric that will ultimately address the issues of errors and complications. That might be something we want to measure.

CHAIR McCLELLAN: Yes. Wei?

DR. YING: One comment. Composite versus individual. We actually just did some

analysis on this question recently since we were in negotiation with a large provider group.

The composite even though if you look at it, it has several of the indicators ARQH has --

(Audio interference)

So for the larger population that there seemed to be more than --

CHAIR McCLELLAN: I think that relates to Nancy's comment about that --

Nancy?

MS. FOSTER: So just carrying on this theme, I know there is work going on, basically an amended version of the IHI trigger tool, looking at all costs and

(Audio interference)

What we really need is for the all -- way to look at that, so that we can then get to affordability. And I think we may, it's one of those places where I think the ARQH PSI 90, which is truly perfect tool. But

there's costs here

So how do we get from where we are right now to where we need to be --

CHAIR McCLELLAN: So it can -- do you have a sense of which is directed -- which of the measures out there are best in terms of roll ups towards all harm? Is it 531? Is it

MR. SAUNDERS: And this is just an opinion, and this is -- I don't' know if we've necessarily got good science on this. I mean as far as composites go, this is one of the few options that is out there and that NQF endorsed.

Nancy's comment is not uncommon and we have heard that from others. That there ware some concerns about this measures. And I think there is interest in some types of all pharms index, but there is still a ways to go until we have a reliable, well defined, NQF endorsed measure in this area.

CHAIR McCLELLAN: Okay.

MS. FOSTER: Just to add to that -

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(Audio interference)

CHAIR McCLELLAN: I was trying to find something specifically to point to to use now to go along with the same -- better.

MS. FOSTER: And along those lines, --

(Audio interference)

CHAIR McCLELLAN: Sean?

DR. MULDOON: Has anyone commented on the BAP? Or measure?

(Audio interference)

Where is cardio use the HSN methodology sometime last year, the CDC for -- BAP as a metric because the internal consistence in accordance with the definition was so random. And instead changed into what they are calling an associated event with some subtypes underneath that.

So this is probably a case where 014, the science and evolution -- the definition is -- probably pretty inconsistent

with the other two metrics.

CHAIR McCLELLAN: Helen?

MS. HASKELL: Just a --

(Audio interference)

DR. THOMAS: You mentioned yesterday about the value of (Audio interference)

There is in addition to the trigger tool, there is a 3M measure called potentially preventable events. Which is in the literature, published in 2012, and it's being used by quite a few health plans in some states. And it's an example of a validated claimed space harm measure that is a roll up and an also be segregated.

Another has just been published I think about this month that Premier worked with it's (Audio interference) networks, developed an automated harm measure tool. And validated against a full medical chart review.

And as with these other mobile measures, that validation is pretty good, but

not in a -- the accuracy could be better. But at any rate there are published values on predictive positives, predictive value negatives.

And that's another example of another rolled up measure that is -- has been used now for about five years by quite a few hospitals in a collaborative improvement network.

The BPE approach that 3M has developed is both outpatient and inpatient, which has real merit. I believe there's a (Audio interference) for both out patient and in patient. And the PP measured by 3M is -- I'm sorry, the primitive measure is limited to inpatient care.

CHAIR McCLELLAN: Thanks for those very helpful directions or current measures that we're aiming for. Helen?

MS. HASKELL: I think these global measures sound great. I just am wondering about the PSA 90 and some of the claims space

measures. I mean they reflect what hospitals are billing and I would think that might be very relevant to affordability.

In addition to just reflecting incidents of things that there might be other reasons to keep those.

CHAIR McCLELLAN: Thanks. Let's see, other comments? So I guess my sense of where we are, based on all this is that we want to acknowledge the work of the errors family and we don't want to duplicate it here. What we really want to do is roll it up into a (Audio interference)

Of the overall -- overall measures is a better predictor of a safe environment for practice, which has considerable implications for cost.

We had some suggestions for measures that are closest to that now. If you all want to go through that more specifically, or if anyone has any other kind of ideas to add about the current nature if we have

limitations I mean, based on claims, there are ways to address that for things like the waiting for the ARQH perspective to better reflect the reliability.

(Audio interference) -- individual elements and the measures to predict a safe environment, could have a systematic impact on costs. And new actions have been suggested for better measures like the ones that have been brought and --

Andy thoughts from here, or further discussion?

DR. TERRY: Yes, I just wanted to mention. So the focus has really been on the hospital side for sure in terms of errors and medicaid problem. You know there are you know, I think when you get the post acute world, there are others. And you know there are pressure ulcer issues and falls and whatever.

So I don't know whether we're talking about measures for specific entities

at this point, or a cross that continue. I know Medicare does have reports for home health that has potentially -- I don't know what they call them, but preventable events. And they have 13 measures that you're measured by and pressure ulcers are one of them among others.

So you know, I do think there's some you could have across systems. And others of course not. So I just wanted to mention that.

CHAIR McCLELLAN: And we do have some related to post acute care. We have some related to hospital. Gene mentioned at least one for ambulatory are as well and I do think the settings are important.

Nancy?

MS. FOSTER: I have no specific measure to offer. But directionally, I think we would fail our field if we don't say something about diagnostic errors and their role in causing all sorts of unnecessary

expenditures as well as harm to patients.

CHAIR McCLELLAN: Yes, that has been a hard one to measure too.

MS. FOSTER: Yes, absolutely difficult. But maybe we're beginning to break off little chunks of it and start down that path to Kevin's admonishment that we begin.

MR. SAUNDERS: And we can also build on the IOM, it's just launched a very large consensus study looking at diagnostic errors. Because probably the diagnostic errors are where we were ten years ago maybe, and overall safety.

So we can certainly talk to those staff and see what we can build on from there.

CHAIR McCLELLAN: Great point. Kevin? Or is that Gene -- Gene do you have something?

DR. NELSON: Yes, just one more comment. It was mentioned earlier in care coordination, a simple item direct from the patient. John Watson once again in Hauser

Health has fielded a single item on patient report of harm.

And once again the rates are fairly high. They do very quite wisely, it's a potential -- that's another potential way of looking at harm using patient reports through some -- some database on that from John Watson.

DR. LARSEN: Yes, this is Kevin, I was just going to say that when I looked at this list, I didn't vote very highly on many of them. Only because they didn't seem like they had a lot of spread across most of what I would think of as a consumer I would want to know about.

One of the troubles with patient safety is that it's rarely occurring events. And it's really hard to aggregate in time and to clinician in a way in a sort of single isolated way like we often do with measures.

So I think this is a place we're going to need more universal like the thing

that Gene mentioned. Or global trigger that's something that's more comprehensive.

There's a lot of methodological problems there for measurement, but you know, foreign body left during procedures, is really, really rare, luckily for us. It does happen. But as the kind of thing as a consumer when I'm looking at it, you know a one in a million chance, versus a one in a five hundred thousand chance. Is that the kind of things that's going to help me decide which clinician is more affordable.

CHAIR McCLELLAN: Yes, and it sounds like there's a lot of interest in something more like a culture of safety measure, or safe environment measure, though there's still more work to do on developing those measures.

David?

DR. SEIDENWURM: Sure, with respect to the diagnostic error piece, you know that's a huge problem. With respect to

-- marrying that with affordability, I would think that the big issue is false positives, which are often under-emphasized in the concept of diagnostic error.

You know we think about the delay in diagnosis. We think about missing something. We think about a lot of things lie that.

But from a cost perspective, from an affordability perspective, I imagine that false positives would be ten to one in terms of cost versus false negatives. So we can't leave that off the table.

CHAIR McCLELLAN: Yes. I guess you know, we touched on some measures related to that earlier. Like you're talking about the mammogram recall rates, and things like that. I guess I just wonder whether we -- I mean do we call that like errors in safety problems? I mean there's also a sort of sensitivity, specificity issue that gets more at over utilization any of what's the right

utilization rate.

So I don't -- I mean we definitely need to cover it. I'm just trying to think of where -- how -- whether that fits into this section, or something that we talked about earlier.

DR. SEIDENWURM: Well I don't know, I mean they're errors. I mean I don't' know where it goes. But just when we talk about diagnosis, we should make sure we include the concept of false positives rather than false negatives. Rather than just focusing as we do traditionally on false negatives.

CHAIR McCLELLAN: Yes, I'm just not sure whether's that in like utilization over use area, or this of like you know, things on this list are things that just shouldn't happen. They're rare events and clear safety problems as opposed to. All right.

Jennifer?

DR. THOMAS: Just to bring the medication side of this to the discussion. There's an obviously a issue with events, but getting at those events is difficult because what most of what we have for reporting is self reported, not really a systematic. So the trigger tool is one of those processes that could improve that.

We just completed a review of claims, a claims data, and about ten percent of Medicare patients have ICD 9 codes that are E-codes that include adverse drug event. Most of that was present on admission.

So what we're identifying is not even what's happening within the facilities, but bringing folks into the facility, so it's probably way under reported.

How do you get to that? I think pharmacy quality alliance is looking at some things based on again, the national plan for prevention of adverse drug events, which is patterned off of the national health care

acquired infections.

And while they have a lab ID event, we still don't have anything. And you know, in creating measures, looking at something from those classes that are mentioned in the prevention plan that are high risk meds, Warfari, anticoagulants, diabetes agents, and opiods, is trying to create measures around at least those.

And I think we have one coming on hypoglycemia at least. But again, you're talking about thousands of meds. Thousands of potential adverse drug events. How do we get at that. And you know it may be the prevention and the safety piece that's the global cause.

CHAIR McCLELLAN: No, that's a big. Medication errors are a huge issue with a lot of the costs.

Helen?

MS. HASKELL: Just looking at these measures thinking that when you talk --

calling patient safety events uncommon, a very common one that is not in here is failure to rescue, so death -- I forget the number Nancy, you would know. But death -- unexpected death in post surgical patients.

Which I think is a really important measure that should be in here.

CHAIR McCLELLAN: Is that a measure? An endorsed measure?

MS. HASKELL: It's a PSA.

MS. FOSTER: It's an ARQH PSI with a --

MS. HASKELL: Is it endorsed?

MS. FOSTER: Yes I believe it's endorsed, and yes I believe it has the lowest level of all the PSIs.

CHAIR McCLELLAN: Just because it's rare, or it's not captured well?

MS. FOSTER: I think it's not captured well in the claims data is the problem. You can probably get a measurement.

MS. HASKELL: Maybe we need to

measure on the accuracies of hospital billing.

MS. FOSTER: Well it's not something you bill for, right?

CHAIR McCLELLAN: That's got to be something I hope won't come through, but.

MS. FOSTER: To the best of my knowledge, no insurance company pays you for failing to rescue somebody, so if it's something you can bill for.

MS. HASKELL: Right, right. It's in the claims data, yes.

MS. FOSTER: And so you need a different way to approach it, which may come through electronic health records. But right, it's the same with an adverse drug event and stuff.

CHAIR McCLELLAN: Is ICD 10 going to fix these problems?

MS. HASKELL: It will help.

CHAIR McCLELLAN: Not immediately probably.

MS. FOSTER: Right. It will still

be an adjustment period. We believe that a --

CHAIR McCLELLAN: Microphone.

MS. FOSTER: It will be helpful, there are codes that get your more specific look at some things, but it will not solve the problems.

DR. NELSON: Comments from Gene.

CHAIR McCLELLAN: Yes, Gene go ahead.

DR. NELSON: All of the claim space measures have -- have a clear reliability and validity problems. For example, the one that Premier developed. I had a hand in that. And sensitivity 65 percent compared to full medical chart review by professional reviewers.

Specificity 85 percent. Predicated value positive 59 percent. Negative Predicated value 88 percent. Concordant 75 percent. And what we concluded and recommended was that was a good measure for use within hospitals over time for

improvement. Not sufficiently accurate for cross hospital comparisons given the results I just mentioned.

And I recently just had the pleasure of talking with Dr. Jim Bagian, James Bagian about so how do we measure harm? And he's as you -- many people know, he's really one of the national authorities on patient safety, and harm reduction. He lead the work at the VA for quite a while and has -- he's now at the University of Michigan.

But at any rate, his opinion was measure culture of safety, which you mentioned earlier Mark. That because of these measurement problems, going for a proximal measure about the safeness of the environment may be not satisfactory, but the best approach was his opinion at this time due to the measurement difficulties.

CHAIR McCLELLAN: Kevin?

DR. LARSEN: Right, I mean this has been just in general a difficult

measurement area like I mean we're talking about again, I have contractors developing a number of these and working with some CMS contractors but, most are around adverse drug events.

What we're trying to figure out if we can do in the first two measures just got NQF endorsed, so I think we're on the right track, is to start taking the lab data and looking at where we know monitoring happens for these risky medications. And actually looking at the lab results and building measures out of those results.

So an example is low blood sugars from too much insulin. Hypoglycemia. So instead of asking -- hoping that a hospital codes that there was a hypoglycemia event, we just look at all the blood sugar data. And then we say how many times was there -- the blood sugar too low and then do a bunch of validation studies.

And those actually work really

well because it's information that's being captured already. It's discrete, it's numeric. And we can apply some pretty good measurement science around issues like that.

We're doing a similar thing in the out patient space with blood thinner and blood thinner monitoring. Have you been monitored frequently enough? And when you're monitored frequently enough, are people actually doing the things they're supposed to do about it?

So they are process measures. But there at least we feel more confident that they're measuring the right kind of processes then some of the process of other measures that we've had.

CHAIR McCLELLAN: Thanks. Nancy, yes.

MS. FOSTER: Switching gears for a moment, Rob could you say a word about, I don't think 709 was on the list. Which is proportion of patients with a chronic condition that have a potentially avoidable

complication during a calendar year.

It's a bridges to excellence measure. And I'm just wondering -- it's apparently being revised at some point, but it seems like a right concept.

MR. SAUNDERS: And yes, I see -- I we actually didn't pull that measure up recently as well. We can certainly look into that measure and see if that might be a good concept here.

I mean I think you're right, this is definitely quite --

CHAIR McCLELLAN: Quite broad.

MR. SAUNDERS: Right.

MS. FOSTER: It does.

CHAIR McCLELLAN: Okay, so I think where we are, after starting out with a long list of measures that at least were reasonable well in our pre-meeting exercise, I think we're ending up supporting pretty much none of them as distinct measures related to errors in safety and affordability.

That I would like the staff to take a kind of closer look back at the roll up measures to see if there is anything endorsed, or close to endorsement. You all have given some suggestions here today that could be a usable measure now that gets more at this kind of you know, this direction of a culture of safety or a safe environment for practice.

Since that's the main thing that we want to get across, I think the biggest implications for cost are from whether the overall environment is safe. So if there's something that gets us close enough to that goal, then we could end up supporting that.

Maybe the ARQH measure that Wei mentioned that has kind of a waiting to reflect reliability for predicting safety issues at an organizational level.

And then we've got some directions for further development that you know, in aiming for measures of safe environment that are likely to predict -- have a significant

impact on cost and affordability. There's some problems with --

(Audio interference)

Incorporate patient reports and the like and you talk about at least a couple of other important related extensions. One was around diagnostic errors and find -- measure that effectively, which could build on the current ILM large study.

And the key -- false positives, so that's an error here, something that was a utilization overuse, I'm not sure at this point.

And then it's like another big area of dissension was around medication errors. And tied to indicate some examples and also some PQA. A lot of PQA activity in this area too. Especially around high risk agents like Warfarin, opiods, oral hypoglycemics and the like.

Okay. Yes, Carl. Koryn welcome. Do you mind introducing yourself for people

who may not have worked with you before.

MS. RUBIN: Hi, Koryn Rubin with American Medical Association. I'm sitting in Carl's seat in his absence. I was in the audience when you guys were discussing the care coordination measures. So can I just make a comment?

CHAIR McCLELLAN: Um-hum.

MS. RUBIN: In regards to the date of service measures and discussion around that.

CHAIR McCLELLAN: So we're going back to the previous session?

MS. RUBIN: Yes, if that's possible?

CHAIR McCLELLAN: Uh-huh.

MS. RUBIN: The -- you know I think from a patient perspective, the convenience aspect, and even from the physician, is nice. They often would like to have the patient there one time and not have to bring them back for multiple date of

service.

But you also have to think about certain coding rules you know, that Medicare has put in place through NCCI edits and the various carrier rules for coverage. So I'm not sure how feasible it is to implement that measure in the current reimbursement world.

And so those are things that need to be considered. Because I know physicians would like to have the patient there and do everything they can that one visit But they're often forced to bring them back for multiple repeat visits for reimbursement.

CHAIR McCLELLAN: Thank you. David?

DR. HOPKINS: So Mark, you know we're all in favor of the culture of safety, but, I really hate to see us lose the emphasis on outcomes that represent harms to patients that were preventable. So could we strengthen that recommendation a little bit?

CHAIR McCLELLAN: Yes. Sorry, I

thought I was trying to -- I definitely meant to capture that. That I'm kind of aiming for a roll up measure of important harms that collectively did the best job of predicting a safe environment. But you know including measures that are based on actual harms and roll ups of those specific harms, I think is important, yes.

DR. HOPKINS: So in that regard, let me throw one more in the hopper. It -- you know it exists, it's not NQF endorsed, but the leap frog safety score is such a composite. So maybe that could be looked at.

CHAIR McCLELLAN: Yes, I would like to have something in this first section of the report on what can be done now in terms of a roll, you know sort of the best available roll up measure or measures.

DR. HOPKINS: And I mean as far as these claim space measures go, I hate to see us you know, get into that discussion about reliability and validity of claims data base

measures. But for so many people who have nothing to guide them, it sure is better than nothing.

CHAIR McCLELLAN: Thanks. Helen?

MS. HASKELL: Well I just wanted to say, I didn't think that we agreed that we didn't think any of these were good. I thought we were actually talking about moving the ones on the right into the left. And then we had the usual discussion about claims data. But --

CHAIR McCLELLAN: Well I guess we should get a clarification from the group on that. It sounds like you're -- you want to keep all of them and then also put emphasis on the you know, the measures that rolled them up.

MS. HASKELL: Well, and you know --

CHAIR McCLELLAN: I thought that more of the group was of the view that while these measures are individually important,

they're covered in the you know other errors family of measures. And that what we wanted to do here was something that's more focused on comprehensive impact on cost.

But that's certainly open for further discussion.

MS. HASKELL: Well, you know, that may be, and I think all of the you know, the things that people described as coming down the pike were extremely helpful, but they're not here yet. And I don't want to throw away what we do have.

And I also wanted to try to add back in failure to rescue, which I had mentioned earlier. Which I think is a huge cost driver in hospitals and with -- if you expand the definition outside of hospitals as well.

CHAIR McCLELLAN: Yes, do you have the -- do you have that measures?

MR. SAUNDERS: NQF 351, and it's not up there.

CHAIR McCLELLAN: Okay. And are other people familiar with that, maybe -- do you want to?

MR. SAUNDERS: Do you want me to do it real quick?

CHAIR McCLELLAN: Yes, while I'm going to get their comments, if you could find it. Wei?

DR. YING: For our hospital contract, we also put in the safety measure related to OB care. It's not part of the composite.

So there are two OB safety measures from the ARQH. They are not great. But those are the ones that we -- only ones that we can find related to the OB care.

I think the fourth degree laceration, with and without instrument, those are the two. And also, for the neonate. Again, that's a pretty high cost if anyone gets into the NICU.

So when our measure we looked at

is NQF endorsed a healthy term newborn, but that measure we actually got some resistence even internally in terms of the definition of what is being defined as healthy term newborn.

So what we are trying to do to see whether there is any NQF endorsement measure on the general NICU use, because of what we identified was a process of analysis is, some hospital just -- they just fail to say respiratory distress as a general diagnosis and put almost all their baby into the NICU.

That becomes a major cost driver for the newborn baby.

CHAIR McCLELLAN: Thank you. Ron?

MS. HASKELL: If I could just comment on that quickly. I mean in terms when you put the things like the C-section rate and early elective deliveries in as cost savers, I think you've absolutely got to have healthy term newborn, or I understand it's being reworked to be a different measure.

Because we don't have any

accounting right now of the results of those measures, we all think they're a good idea. But we you know, we don't really what effect they're having. So I think it's really important to have both.

DR. YING: We actually look at the correlation between elective delivery versus -- and the healthy term newborn. They have high correlation.

The ones who had the -- had elected -- higher elective delivery has lower rate of healthy term newborn. So as we expected.

CHAIR McCLELLAN: Ron?

DR. WALTERS: For the recent round of names going up, I thought I was going to be speaking in the minority. I agree. I think there's a role for commenting about areas of direction that we think things can be better served with.

I think there's certainly a role for commenting about gaps that aren't on this

list. But I was getting a little worried when we started heading towards the direction of throwing the things in the left hand column off the list totally. Those are all key drivers of cost. And therefore figure very much into affordability.

And I also don't believe it is the purview of this committee to comment on about endorsed measures just because they may be imperfect in nature. Our purview is to comment as to their applicability to the affordability side of things.

And if we -- we took a turn in direction I think from yesterday where we accepted the list of measures that existed and were NQF endorsed and talked about those from affordability. And today we started drifting into trying to redo measures.

And that's up to the measure developers and other committees. So I just think --

CHAIR McCLELLAN: Well just a

clarification on that. I mean my -- my take on the comments were not that it was a question about do these NQF endorsed measures serve some purpose, it's whether if they're not as reliable predictors of sort of systematic issues of the organization level, they may not be as good for predicating costs.

And that's why there was this kind of push towards measures that you know, sort of put together all of these elements as a better predicator of costs. So and I don't think there was any effort to sort of impugn the NQF endorsement process.

But, oh David, good, go ahead.

Well, we are trying to wrap up, so.

COURT REPORTER: Sir, could you put your microphone on please.

DR. SEIDENWURM: Back quickly to the false positive issue, and I don't want to belabor it, but I am thinking more and more that it is analogous to a surgical

complication, or a medical error. Because you are subjecting a patient to more medical activity to fix a problem that you've caused.

So I think perhaps the locus within the report could be here, if that's a coherent thought.

CHAIR McCLELLAN: Yes, sounds good. So I do want to go back to what goes in our -- you know, sort of what do we recommend now as a focus for -- as inclusion for an affordability family of measures.

And so one option would be that the best roll up measures is the second option based on comments from Helen, Ron and others would be look, each of these specific NQF endorsed measures has a piece of predicating costs. I mean they're all related to costs that shouldn't happen.

So we could include them and also emphasize the need for roll up measures that may be better at the system level. So it could go -- we could go either way with that.

Is something like that approach?

I see some heads nodding. Okay, so we'd still put the emphasis on wanting -- you know what we really want is roll up measures that are best predictors at the organization level for safe care environments. But these are NQF endorse because they do amount to avoidable costs, we want to mention them too.

MR. SAUNDERS: Let me just to repeat.

CHAIR McCLELLAN: Um-hum.

MR. SAUNDERS: Just to repeat back then. So we were talking about all of the measures on the left. And are we also adding the two ARQHs, the 531 and 532 to that list. Are there any other measures. Or just to make sure that staff record this accurately.

CHAIR McCLELLAN: Joanne?

DR. CONROY: I just think there is some conversation to remove the foreign body left during procedure because it's hard to --

it's uncommon. It's important, but it's uncommon if we're talking about affordability. That really would belong more in complication conversation, not linked to affordability, so.

CHAIR McCLELLAN: Is it any less common then wrong site? So maybe an intermediate step would be a comment that those two in particular are quite rare, and probably are not -- yeah. Probably are not going to be big predictors of cost.

And again, I think that fits with the theme of getting to or roll up measure that is a better overall predictor of cost and safety.

Nancy?

MS. FOSTER: So I'm not crafting your roll up measure for you, but because they are similarly infrequent, I would think that 363 and 267 aren't driving costs.

CHAIR McCLELLAN: Yes. That's what we were just talking about is an intermediate way of handling this.

MS. FOSTER: That's affordability in the general. Which is not say taken out of the safety family, but it says if you're looking for affordability, this isn't going to get you very far down the road.

CHAIR McCLELLAN: Aparna? Oh, sorry, did you have another comment?

MS. FOSTER: Yes, I did. And I'm -- I'm going to say this. Please, please understand I don't mean it as bluntly as I'm about to say it. But I think there's a danger in including some of the measures like Helen let me take it up on the failure to rescue. One might actually in looking at cost find that death was less costly then maintaining the life of that patient who obviously had something very seriously wrong with him to begin with.

And so I am not speaking to taking these things out of the safety bucket. That that's not our purview for today and I'm not talking about that. But in terms of

affordability, I just raise the caution that we may have some perverse things happening if we're including some of these measures in affordability.

MS. HASKELL: Well, I think some of these things, I mean the point of that measure is unexpected deaths of the patient, did not have something seriously wrong with them originally. So the idea is that this was a hospital acquired a condition.

It's an unexpected death right? Am I thinking of the wrong measure?

MS. FOSTER: Failure to rescue means that they had something very seriously wrong with them that would have required a rescue.

MS. HASKELL: Right, but --

MS. FOSTER: And someone failed to rescue them.

MS. HASKELL: The measure I'm thinking about, I don't want to get to much in to -- the measure I'm thinking of is

unexpected deaths in a post-surgical patient, which you know, indicates that from a complication, that they wouldn't -- you know, so the complication was hospital acquired and was not recognized.

CHAIR McCLELLAN: I do think it's helpful to make the distinction between the purpose of as you were implying, the purpose of the safety family, which is about safety, and the purpose of the affordability family, which is about cost.

And as we've said from the beginning, is not meant to be looked at in isolation from quality and other measures. So you know we -- this may be a little bit difficult to finesse, and it may be something we can come back to in comments on the actual report.

But I think if we can put that comment up first, then --

MS. HASKELL: Well, I mean you know, I think things like that are a major

cost driver.

CHAIR McCLELLAN: Right.

MS. HASKELL: Because that's like people in the --

CHAIR McCLELLAN: Right, that's right, if it is a major cost driver, then that's the kind of thing that would be included here. If it's not, then it would be less important and then that leads into our kind of weighted roll up measures that predict safety issues at a systemic level.

MS. HASKELL: So you give someone going in for a minor procedure and they end up in ICU for 30 days or --

CHAIR McCLELLAN: Right. And so I think what we'd ask the staff to do is try to do the best of a pass they can at what's the evidence that some of these safety measures really do predict higher costs and those would be the ones that we particularly want to emphasize for this group.

Aparna?

MS. HIGGINS: So I --

CHAIR McCLELLAN: Microphone.

MS. HIGGINS: I would agree with that Mark, and I just want to -- and I think on some of these things, and I don't know what the evidence is obviously, and staff's going to do some work, but.

You know, so for example with -- you could have you know, low frequency, high cost events. And I don't' know how much of these fall into that bucket. Obviously so I think that remains to be seen.

But for example with you know, something like wrong site, wrong side, I could see it's not just the direct cost but indirect cost for example. And I know we talked about this yesterday. So some of the down stream effects which are not necessarily captured.

So it would be you know, so if somebody cut off my right arm instead of something else, then you know, now I'm looking at loss of wages and all these other effects.

So I think you know, it also depends upon sort of other indirect impacts as well, so.

CHAIR McCLELLAN: Thanks. Jim?

DR. DUNFORD: I was just going to us as an example that there's a report from HHS yesterday that came out that reports, this is the kind of thing that as a customer -- consumer you're going to be reading you known new HHS desk shows major strides in patient safety leading to improved care and savings.

And so they have their ventilator associated pneumonia, early elected delivery, OB trauma rate, venous thromboembolism, falls and trauma and pressure sores. And that's a nice --

CHAIR McCLELLAN: Well those are all pretty common.

DR. DUNFORD: Yes, that's a nice package that people can look at and they can associate that with X $4.1 billion reduction in costs. So I think that that's what -- I think you need specific examples.

And then some of the aggregate ones I think also put it in context for the other issues. But I think it's important to have some of these broken out as they are.

CHAIR McCLELLAN: Okay. We have a little bit of work in editing. So remember you're going to get another crack at this when it comes back around.

All right, I think we're at a point now where we need to ask about public comments. So operator if you're on with us, could you open up the lines.

OPERATOR: Please respond to make a comment please press star then the number one. There are no public comments at this time.

CHAIR McCLELLAN: Okay, thanks very much operator. And that means we are now breaking for lunch. So we've got 30 minutes until 12:30 when we're going to start back with a segment on alignment with a work of the MAP population health and personal family

centered care, task forces and measure selection and gap identification for mis-prevention opportunities and person and family centered care.

God, I got that all out in one voice. This is -- this really about -- this is going to include a lot of discussion around person reported measures.

So put on your thinking hat for that topic. I know it's come up in some of our previous discussions. But we're going to try to talk about caps, measures, other related patient reported measures too. Okay.

(Whereupon, the above-entitled matter went off the record at 12:00 p.m. and resumed at 12:30 p.m.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(12:30 p.m.)

DR. MCCLELLAN: All right. Welcome back from the lunch break. So the title for this session is kind of a mouthful, but it's really two important and related concepts that I think will fit well together in discussion.

This is about alignment with some other activities going on in the MAP. The MAP Population Health and Person- and Family-Centered Care Task Forces are obviously areas that overlap a lot with opportunities around affordability.

And so we're going to hear from some of the staff leads for each of these groups and then use that as a way to lead into our discussion of measure selection, gap identification around missed prevention opportunities and improving person- and family-centered care.

So we're very pleased to have

Allen and Mitra with us today. I'll ask you all to introduce yourselves as you start your walkthrough of some of the work that your task forces are doing.

Just as an up-front comment, there are not any specific measures from the prevention family, at least so far, that we see as clearly related to the cost, but I know there's going to be some good discussion around that.

And in the patient-centered family there are some opportunities as well, mainly, as I mentioned earlier, related to CAHPS, but perhaps some other areas, too.

So, Rob, any other intro comments for this section?

MR. SAUNDERS: No, and just real quickly, I think just like the previous two sessions where we've talked about aligning this work with previous families on care coordination and safety. The goal is here is to think about their work, which is really

diving into what are the important population health, or what are the important patient- and family-centered care issues, and then take in an affordability lens to it.

And all three of our families will be in the same report, so it will be important to make sure that we're aligned on the measures that are identified in these areas. And that's it.

DR. MCCLELLAN: Okay, great. So who's up first?

MR. SAUNDERS: We'll do Person and Family Centered Care.

DR. MCCLELLAN: Okay.

MS. GHAZINOUR: Good afternoon, everyone. My name is Mitra Ghazinour. I am a Project Manager supporting the MAP Person and Family Centered Care Task Force.

And, so, similar to the Affordability Task Force, this task force convened in March to identify the high-leverage opportunities and measurement areas

to promote person- and family-centered care.

So this task force is focusing on the NQF's priority of engaging patients, engaging persons and families as partners in their care. And also focusing on advancing the goals of this NQF priority, which is to improve the experience of persons, families, and caregivers, improve their experiences of care. And also encouraging partnership between persons, families, and caregivers in developing care plans that incorporate their preferences, values, and goals. And, lastly, to empower persons and families to be able to manage and coordinate their own care.

So the Task Force defined -- actually this definition, we have other NQF projects that are also focusing on this topical area, and this definition has evolved and has been developed through other work at NQF, with Kevin Larsen also leading that work. It's called Measure Gaps: Person-Centered Care and Outcomes.

So we have been using that definition in order to be aligned, our recommendations to be in alignment. So person- and family-centered care is defined as an approach to the planning and delivery of care across settings and time that is centered around collaborative partnerships among individuals. They are defined family and providers of care and it supports health and well-being by being anchored by, respectful of, and responsive to an individual's preferences, needs, and values.

And so according to this definition. and as I discussed NQF's priority and goals, the Task Force identified four high-leverage opportunities of experience of care, quality of life, and patient and family engagement, and lastly, but not the least, access to self-management support.

The experience of care includes measurement areas of dignity, respect, compassion, and equity for all people, all

persons receiving healthcare. Care integration, which will include care coordination and care transitions. And also provider communication and collaboration.

Quality of life is a broad concept which could entail all these measurement areas, including functional and cognitive and mental health assessment and improvement, physical, social, emotional, and spiritual support and well-being, symptom and symptom burden and treatment burden.

And also the Task Force deemed patient and family engagement as a high priority for measurement, which entails establishment and attainment of patient and family caregiver goals, shared decision-making, advanced care planning that expands beyond end of life care planning and includes care planning for people with multiple chronic conditions and complex illnesses. And also care that is in concordance with individual values and preferences.

And so the last one is access to self-management and support which includes patient activation, health literacy, cultural and linguistic competency, and caregiver needs and supports.

And so the Task Force will convene this Monday via an in-person meeting to identify measures and high priority gap areas regarding these high-leverage opportunities and measurement areas.

That concludes my presentation. Thank you.

DR. MCCLELLAN: Great. Thanks very much, Mitra, and I think are we now going to preventions?

So we are going to have plenty of time for discussion, but if there are any clarifying questions now --

MS. RUBIN: Yes. How does this relate to all the other NQF work going on around, you know, linking cost and quality, cost and resource use, you know, and the

evaluation that MAP is doing in affordability space --

MR. SAUNDERS: That's the next session, so we'll have time.

DR. LEAVENS: Great. I'm Allen Leavens, the Senior Director in Strategic Partnerships at NQF. And we actually had both a web meeting and an in-person meeting for the MAP Population Health Task Force, which similar to Patient and Family Engagement and the Affordability Task Forces, we discussed high-leverage opportunities for population health improvement based on the National Quality Strategy goal of working with communities to promote wide use of practices to enable healthy living.

And what's a little unique about this priority area is that it focuses much more on health rather than healthcare. And if you look at the long term goals specified in the National Quality Strategy, you can see an emphasis on social, economic and environmental

factors, which are many times outside of the healthcare domain.

Healthy behaviors, which can be addressed through counseling, but, again, a lot of those are outside of the healthcare setting.

And then the last one, effective clinical preventative services, which tends to be clearly much more healthcare-oriented.

But what we based our discussions off of was thinking about what role factors outside of the healthcare system play in overall health. And when you look at work by Francis Kendig with the County Health Rankings, they did an assessment and showed that healthcare is actually about 20 percent of health. So if you're thinking about 80 percent of the determinants of health are outside of the healthcare setting, you know, it's something that's pretty much under-represented in terms of measurement, because much of measurement focuses on healthcare.

So that's something that that group kept in mind when they were choosing potential measures for the family. And then you can see that the two measures that were highlighted as initial indicators for population health and the National Quality Strategy focusing on depression and obesity.

So our Task Force used three broad categories of determinants of health, health improvement activities, and health outcomes to guide their thinking. And then dove a little deeper to come up with these specific topic areas which were felt to be high-leverage opportunities for improvement in population health.

And it should be pretty self-explanatory, but, again, a pretty diverse range of topics and many of these focusing on issues that are outside of the healthcare setting.

So I'll spend a little bit of time on this just because this was something that

the Task Force thought would be particularly helpful in their work in terms of applying the measures, which is what MAP is all about, measure application.

So they thought it would be helpful to develop use cases for how the measures in the family might be applied. So in the past, the families have been used primarily for helping MAP to think about the programs that CMS administers. And those are all in the healthcare setting pretty much.

So the measures that were selected based on this use case were things like screening, controlling high blood pressure and diabetes, immunizations, et cetera. So these are all clearly things that apply to existing CMS programs, and a number of those measures were preliminarily selected.

So taking that one step further is looking at Accountable Care Organizations. Now, there is the Medicare Shared Savings Program, which gets into some of these

concepts. But thinking even a little more broadly, looking at system-level measures that may apply across providers or healthcare settings. And so thinking about an annual dental visit that may not be something that one provider knows about, but if you have a comprehensive system and you're tracking whether patients in that ACO are getting services outside of just one provider, those are some additional measures that may be applied.

Community health needs assessment, as many of you know, is now a requirement for non-profit hospitals. And it takes a little bit broader focus, not just on a healthcare population, but a geographic population that may be surrounding a hospital.

And so with this application you may think about measures that are even reaching more beyond the healthcare setting, and so this example of looking at the number of school days that children missed due to

illness.

And so those are the three use cases we started with. During the meeting the group actually wanted to take it a step further and think about measures that would be just very public health-focused. So this may be for a health department or a social services agency, and thinking about very upstream determinants of health.

And so for this use case, there was a few NQF endorsed measures, but a number of the measures that were selected were actually leading health indicators that are part of Healthy People 2020, but the group felt that it was important to include those because these really, again, address very upstream health determinants and also focus more on geographic populations.

So it could be at a county level, a state level, or even a national level in the case of the Leading Health Indicators.

So that was the focus of the MAP

Population Health Task Force and I'll turn it back to you.

DR. MCCLELLAN: Thanks. Any clarifying questions for Allen before we turn to measures and discuss some measures with help from Mitra and Allen? Okay, great.

So, moving on, this table lists some of the preliminary measures that you all considered and favored for person- and family-centered care and prevention measures, sort of an aspect of the emphasis on community health, population health, relevant to cost.

And if you look at the measures in the lefthand column, those are all various CAHPS measures, with one exception, the advanced care plan metric. So we might put together some of the CAHPS related discussions. In fact, a lot of stuff in the not selected but considered is also -- in fact, all of it is CAHPS-related as well.

Obviously, there are some potential measurement gaps and opportunities

beyond that as well, and I don't know if we want to hold on this slide and save the more extensive prevention discussion for -- oh, right. You've got one prevention near the bottom.

So the thing with the prevention measures, as you just heard from Allen, there are a lot that are obviously very relevant to population health. The evidence on cost impacts and affordability impacts is less clear.

So once again, as in our other discussions, not that these are unimportant areas enough that they should be considered along with affordability, but we're trying to keep our focus here on the affordability family and therefore the implications directly on cost.

So maybe we could start with the person- and family-centered care section, and after we've gone through that maybe turn to prevention and other population health

potential measurement areas.

And preliminary questions there are pretty our usual ones: what do you think of the preliminary measure, the preliminary list of recommended measures, are there others that should be included? And, you know, these are areas that are both, obviously, very important and still in further development.

So maybe some comments related to next steps and future directions would be even more important here. Kevin?

DR. LARSEN: I apologize, I have to leave at two for a call, but as you saw from the previous slides there were some other domains besides experience, things like outcomes, that have been identified as really key for patient- and family-centered care.

And a couple of those I think might be appropriate here. I'm thinking specifically of depression in remission, you measuring with the PHQ-9. There is some good work through the Minnesota Diamond Project of

how that has been shown to correlate with more days at work for people that have depression.

And so it actually has an affordability, not necessarily in the healthcare space, but it has an affordability to the people that matter, that you're actually at work more and your employer likes that. And most people like that as well.

I think that that will likely start to be demonstrated in other patient-reported outcome measures. I think there is some similar work in the asthma control measure, which measures children's or adult's control of their asthma. And we know that children that have uncontrolled asthma miss more school and adults that have uncontrolled asthma also miss more work.

So I would put a plug in for including here some PRO measures, those two specifically.

DR. MCCLELLAN: Thanks. Peg?

DR. TERRY: I think on depression

there is some evidence out there that if patients are depressed they don't engage as much and so they don't engage and they don't improve.

And so it can have an affordability issue. But the other thing I wanted to raise was, I'm sure people are familiar, and in the area of home care we do a lot with patient engagement and patient activation. And so I'm sure people are familiar with the PAM tool, you know, which is not publicly available per se at this point.

But many of our members are using it and they're finding that it's a good tool for them to measure a patient's ability to improve. So, again, how you tie that into affordability though is another, you know, a bit of a leap but --

DR. MCCLELLAN: I think here is some evidence, and Kevin or others might want to comment on this, too, about more engaged patients using healthcare more effectively,

being more engaged in a care plan, which in turn has, you know, significant costs as well as out outcome --

DR. TERRY: Right. And I think health literacy is another issue that, I don't know that there's a good measure today on health literacy, but it is part of engagement, too. And how patients, you know, are able to engage based on their literacy level, based on, you know, again, how you get to them, how quickly you get to them, how quickly they grasp what they need to do. And so I think some measure along that lines, I think, would be helpful.

DR. MCCLELLAN: Thanks. David and David?

DR. HOPKINS: So since CAHPS is all over this chart, I can't help but comment that CAHPS as we know it has, from what I conceive, virtually no relevance to affordability.

But isn't part of our job to

suggest to those who can help make things change, and in this case I'm thinking of the CAHPS team and ARHQ that commissions them, to for goodness' sake start thinking about affordability as an area that should be explored to the CAHPS service.

DR. MCCLELLAN: So and that would be just some of the direct questions about impactive out-of-pocket-costs on your care or things like that?

DR. HOPKINS: This is patient experience, right? It fits right in there.

DR. MCCLELLAN: Okay. David?

DR. SEIDENWURM: I think that it would be worth commenting just for a second that there is some work that suggests that patient satisfaction and patient engagement result in higher cost and higher utilization.

So I'm not saying that that's necessarily a bad thing, I mean, but it is something in an affordability conversation that has to be mentioned, I think.

DR. MCCLELLAN: Helen?

MS. HASKELL: Well, when you're talking about prevention, I get very uneasy when you start bringing things like depression, which I assume is depression screening, because I think that is a -- and particularly when you're talking about people who have had symptoms within the past 12 months as opposed to necessarily long term -- I think that is a ticket to over-treatment, which is certainly not an improvement in affordability and often not an improvement in outcome. So when you measure things like --

DR. MCCLELLAN: Impact on work --

MS. HASKELL: Well, yes, the depression going away, you're still not measuring the effectiveness of the treatment. I mean, there's also plenty of research out there saying that antidepressants don't work, but when you say treatment for depression that's what people get.

So I think there's some real

issues around screening and particularly in terms of cost, because I think the cost of screening is high, unless it is something that's really shown to be effective.

DR. MCCLELLAN: Yeah, and I think, I mean, maybe that is a point for our broader discussion. Kevin brought this up earlier, too, you know, that kind of the better evidence of more effective treatment of depression or asthma or other conditions is not short term healthcare cost savings, but, you know, at least offsetting savings in other areas as well as longer term better outcomes, and maybe avoided complications in the future. And that's at least a point that we should probably note in our report if we do move forward with some of these recommendations.

DR. LARSEN: Yeah, so the thing I was actually referencing is are these patient-reported outcomes, which are standardized scales that measure a baseline, and through time are you getting better?

And the groups that focus on that use many tools, including antidepressants, but also therapy, any number of tools to help achieve a better outcome. And they know they have a better outcome because they are using a standardized tool of symptoms, essentially, of depression.

So it's people that have the outcome of less depression symptoms are the people that have less missed days of work. And it's the same with asthma. It's not measuring did you take the medicines, it's a standardized assessment of is your asthma controlled.

And that is what leads to less ER visits, that's what leads to less missed days of school, and less missed days of work. And so that's the sort of promise of the patient-reported outcomes.

MS. HASKELL: No, I think patient-reported outcomes and screening are very different. And my concern is the screening,

getting people into treatment who might not need treatment, who then might well report a good outcome with or without treatment.

I just think there are real issues there because these treatments are not without harms and they're certainly not without cost.

DR. MCCLELLAN: Koryn?

MS. RUBIN: So in regard to HCAHPS and the affordability, I mean, there's a possibility there's some questions in there that may actually be driving up costs, particularly in regards to the pain management questions. And that's something I've been regularly recently hearing from physicians.

Their concern and their issue with being judged on pain management given, you know, that's a subjective thing, and based on whatever the patient is in there for, their tolerance for pain is different. And with the opioid problem that we have in this country, there's a real concern from physicians that their care is being judged based on how the

patient feels with how their pain was controlled in the hospital.

DR. MCCLELLAN: Thanks. Wei?

DR. YING: One thing about patient-reported outcomes, the issue we run into is PHQ-9, when physicians use it they actually come up, I think it's the standardized treatment suggestion. So if it's between zero to five, do nothing; five to ten, do this; ten to 15, do this.

So there is a standard treatment plan per se. Of course every person is different, so they can vary a little bit, but there is a standard structure there. But when we try to do the hip and knee, we run into problem because the physicians see the score but they don't know what to do with it.

So that will lead to sometimes unnecessary use or even inappropriate use. So use the prompt, instead of at the very end and just retroactively say, well, yes, it happened, to make it become part of the

treatment to control the cost to make the care better. The developer, or I don't know who, needs to come up with something to pair with the tool itself in terms of the standardized treatment plan, or at least a suggestion if it's not a standardized --

DR. MCCLELLAN: Pair it with a standardized treatment plan which would also give more confidence about the cost impacts of this. Nancy and Aparna?

MS. FOSTER: So I don't have any great passion around the 0326 Advanced Care Plan, which just records whether a patient age 65 and older has one, but it seems lackluster absent the measure that says, was it followed, was it adhered to when they came to end of life or whatever advanced care planning they've done.

And having recently gone through a family experience with this, I can tell you there are all sorts of state laws that get in the way here. So I'm just nervous about what

that particular measure would tell us vis-a-vis affordability, let alone anything else.

DR. MCCLELLAN: Aparna?

MS. HIGGINS: So I just wanted to echo David's comments about I'm not seeing the link between these CAHPS surveys and affordability, so, I mean, as they are.

I know it's a long survey so I, you know -- and I think some of the types of measures that, you know, Kevin was describing to me seemed much more relevant to what we're trying to do here.

DR. MCCLELLAN: So patient reported outcomes about control of the chronic conditions?

MS. HIGGINS: Asthma, yeah.

DR. MCCLELLAN: Yes. Okay.

MS. HIGGINS: Depression.

DR. MCCLELLAN: Yes.

DR. SEIDENWURM: Is it appropriate to have those patient-reported measures as a control that maybe some of the other

affordability measures aren't reducing the quality of the patient experience? Maybe that's why we have those --

DR. MCCLELLAN: Well, that's balancing measures and we're going to talk about that in the next session.

DR. SEIDENWURM: Right. Okay.

DR. MCCLELLAN: And I think that is -- you know, if it's not affordability that doesn't mean it shouldn't be considered with affordability, but it probably does mean it's not part of this family. Yeah, Gerri?

DR. LAMB: Yeah, along with what everybody is saying, I'm sitting here wondering, so, what is it within person and family that really does drive cost? And I think, Mark, you had mentioned some of the beginning work in engagement suggests, like Judith Hibbard's work, suggests that it does have a cost impact, but that's really very early on.

DR. MCCLELLAN: Yeah, that's

right.

DR. LAMB: And so, you know, I guess the other one that I was wondering --

DR. MCCLELLAN: Yeah, we're going to go ahead and put up the gap slide which highlights these --

DR. LAMB: Go back for a sec, though, the 1902 -- what is the literacy one? Is that getting anywhere near, you know, something that might impact the ability to make decisions about health services or use them? What is that one actually measuring?

DR. MCCLELLAN: While we're looking at that, Kevin, any comments about evidence on literacy and impact on cost?

DR. LARSEN: So, I don't know about interventions. When I was doing research we were in the space of looking at could health literacy interventions actually decrease cost.

There's a really high correlation between low literacy and increased costs, but

the literature on whether or not we can intervene in effective ways and lower the cost is far less robust.

There is some work done in certain places, like diabetes care, that I think has started to show it. The work has morphed is into care coordination work, frankly, because it turns out not to be really about the printed materials, but more about what's the experience of care and how is it as straightforward to get the care you need versus how much you need to have high literacy to work your way through a really complex system with lots of barriers and disconnectedness.

So there, yeah, I think the data to date is low on interventions.

MR. SAUNDERS: And to jump in on 1902, so 1902 is a composite that's built out of the CG-CAHPS survey which includes basically questions about communications with doctor, provider, disease self-management,

communication about meds, communications about test results, and communication about forms.

So it doesn't necessarily get to I think your question exactly. It's trying to say did the provider, you know, use the appropriate types of communication which hopefully would be useful for improving health literacy?

DR. LAMB: Along those lines, the domains that are being looked at for care coordination now have literacy, but it's in the structural variable column in terms of impacting, so it's pretty far downstream from what we're talking about here.

DR. MCCLELLAN: Yeah. Aparna?

MS. HIGGINS: So I'm sort of pondering a little bit David's earlier suggestion about adding questions to CAHPS, and I'm wondering if maybe we should think about some more sort of global measures like, you know, what percent of your income you spend on healthcare, for example, would be

sort of a good way to look at, you know, the affordability.

In the context of a survey, you know, or, for example, I don't know if, you know, data sets like MEPS would allow us to get at that. You know it might be other sources beyond surveys to try to get at that particular issue about, you know, share of income spent.

You look at share of income spent on food and housing and so forth, so healthcare would be, you know, one such --

DR. MCCLELLAN: There are a lot of survey questions about affordability and whether cost impacted care.

MS. HIGGINS: Right. And the other issue I think tied into that is the opportunity cost, so, you know, what else -- it's kind of like the same crowding out effect that we talk about of government spending.

At the individual level, like, what did you forego because you had to spend,

you know, twice as much on healthcare, for example.

DR. MCCLELLAN: Kevin?

DR. LARSEN: Yeah, some additional thought about caregivers, I think, is key here because we know that for many of these patients and conditions a huge financial burden is born by their caregiver.

So if you think of a parent of a child who's chronically ill, that's a pretty straightforward one, but what's less straightforward is the child of a parent who is cognitively declining but still living at home and trying to navigate a really complex set of healthcare systems and services. And the amount of spend on behalf of that child of the elderly person could be quite high.

It's an important component as we think about person- and family-centered care and it's part of the reason we talk about here. One of the drivers for things like nursing home admissions, I think most of you

know this, one of the common reasons you enter into a long term care is incontinence and that's because it's so much a challenge to manage at home and it costs to manage at home.

So I don't think we have anything there yet and it's not going to be an easy one, but I think it's pretty impactful.

DR. MCCLELLAN: Thanks. Don?

MR. MAY: You know, I don't have a measure here, but I think that as we talk about getting information from patients we're seeing through some of our companies that, device companies are trying to use wireless communications, personal handheld devices to start to collect information and finding a way to add that to the information that we are collecting from people is I think going to be very important.

We're already seeing in cardiac care where people with COPD can go home and there's a monitor that's wirelessly sticking to some device, I think it's an iPhone or some

kind of app in the home, the thing gets transferred to the physician.

You know I think historically we've seen very little growth in that from a real perspective, I mean where technology could really improve collection of information from the patient because, to be honest, as we've talked to device companies, there's not a lot of, there was no way of incentivizing that.

But as hospitals are trying to prevent readmissions and that's where the cardiac care project started, they were trying to prevent readmissions, and all of a sudden there was a real interest in having this wireless technology communicate information.

And I think, you know, that's an example that maybe gets more care coordination, but I think, you know, whether it's I have a Fitbit and I can tell you on my phone how many steps I make and then that goes up to the web and tells my friends, you know,

I think there's opportunities here to be thinking creatively about how to get information from patients in a different way other than just a survey.

DR. MCCLELLAN: All right, thanks. Peg?

DR. TERRY: So as Aparna, is that how you say it --

MS. HIGGINS: Yes.

DR. TERRY: -- was speaking and she said "well" at the end maybe it's what, you know, how you make decisions about getting one thing as opposed to another and I know there's been a lot of discussion that patients don't get their meds filled because they have to buy food or whatever it is, there's a lot of, you know, discussion around that.

But I do think that's an important way to get at the issue for some people and I don't know what survey it could be in, but I think there is a way to kind of look at, you know, you make decisions about what you can

afford and some things you can't afford if you're having a heart attack possibly.

But there are other things that you make decisions on affording and so the question, you know, how do you embed something that says well, have you decided not to do, and meds are a good one, but have you decided not to do this because, you know, it's something you decided you needed to spend money on something else or something like that.

So I don't know if it could be in an HCAHPS or what, but, or another CAHP, you know, one of the CAHPS or somewhere else, but I think making decisions about the affordability is a really concrete way maybe of getting at it, to get some of the --

DR. MCCLELLAN: Thanks. Jim and Helen?

DR. DUNFORD: Just picking up on Don's point. I was impressed by the Camden Collaboratives success in bending the cost

curve of their superuse and population because they basically partnered with the faith-based community and they worked with the Baptist churches and it was really those care providers that actually were the glue that kind of stabilized the situation.

And I think using those kind of community-based resources to be able to copy the whisper that begins to describe when there's a problem brewing and then communicating that information back to the primary care physician team is really an untapped resource.

Kevin and I were just talking about this awhile ago, this sort of ability to train people to use simple social techniques and wireless services to be able to start to push information to caregivers is actually going to be really a powerful tool.

And so the gap is basically identifying, you know, what are the valuable points that we need to know, you know. I mean

there may be a car, but there may not be a car today to get to the doctor's office, that's a huge differential.

And there may be, you know, no air in the tires or ten other things that can cause transportation to be the issue just this week and maybe next week it isn't going to be the issue.

So something has to be fairly dynamic, particularly for hyper-vulnerable people.

DR. MCCLELLAN: And that is a connection between, especially for high, as you said high risk or hyper-vulnerable individuals, these non-medical support connections seem to be very important as the rolling evidence on that from Camden and lots of other places including, Kevin, your old home.

I'm not clear on what a measure of that would be that we could recommend though. I mean I think it's one thing to talk about

the directionality, but --

DR. LARSEN: If I could speak up? There are a couple groups working on this, kind of in a backdoor way. So there's actually a vendor, an interesting kind of not-for-profit vendor that goes into clinics and helps patients fill out a survey of I need food, I need help with forms, I need help with transportation, and then they get college volunteers that they've trained to connect these patients to those services.

Well that survey then becomes a measurement, because now it's quite standardized, it's structured, it's in actually a number of different communities across the country and they've done a lot of work with the informatics on structuring their survey and they can actually show to practices the improvement they make on those sort of survey scores and the linkages to community services and then, and they're now working on how that's decreasing healthcare costs when

people have had these other kind of service needs met.

DR. MCCLELLAN: So that's a health leads and --

DR. LARSEN: It's health leads, exactly.

DR. MCCLELLAN: -- you know, some other groups that --

DR. LARSEN: There's some other groups that did it.

DR. MCCLELLAN: Yes.

DR. LARSEN: It's that you could imagine a model where you take this sort of health leads idea and then build it into survey.

I know that groups like United Healthcare in all of their care coordinations, we have been thinking along the same way.

What are the key questions that we ask that tell us, for example, who needs additional home services, who needs additional care coordination, so they can identify those

people, get targeted services like Camden does, and know that they've decreased costs.

DR. MCCLELLAN: Yes, thanks. Helen?

MS. HASKELL: Well much less global really, but going back here, I think shared decision making and informed choice are really critical to reducing costs, so getting that really right up at the beginning so that people know what their options are.

And the other end of that is patient reporting after adverse events and patient involvement, you know, in investigation of adverse events so that you get the information to prevent them fed back into the system.

And then, you know, along the lines of what Kevin and Jim were just talking about, behavioral health, the flip side of what I was saying earlier about depression is that we, is the lack of resources for people with severe behavioral health issues and I

wonder if there is not a way to survey for that, you know, or do some sort of survey that would, a measure that would push communities to put programs like this into place.

DR. MCCLELLAN: Thanks. Next I have Wei.

DR. YING: I'm also a member of the population group so I can actually, I'm actually looking at a measure we voted on. There's one measure, it's not getting at the productivity per se, but basically the measure is the number of school days children miss due to illness.

So that's the only one that's from children, you get to the parents a little bit, so it's some, at the surface, just to touch on the concept that we're talking about, indirect cost, that's one thing I wanted to point out.

The other thing is during that group's discussion obesity and smoking, everyone recognized from the population point of view that those are the leading factors for

the downstream costs later on.

I'm not sure whether for this work group do we want to add anything, since we didn't touch anything on that? I think smoking cessation is part of the CAHPS survey or some survey that health plan actually does to their, basically requires to the --

(Simultaneous speaking.)

DR. MCCLELLAN: Yes, there's some direct measures on that.

DR. YING: Yes.

DR. MCCLELLAN: I think the cost impact, again, is a bit less clear. I mean those conditions are associated with higher costs, particularly obesity.

DR. YING: Right.

DR. MCCLELLAN: And so I think maybe, you know, smoking and obesity in particular are on the list of measurement gap areas. So I'm actually guessing maybe like a smoking cessation measure could be --

MR. DYER: Smoking and for the

BMI. I think for the population health, for the population group they have those in specific measures targeting the obesity and the smoking.

DR. MCCLELLAN: Yes.

DR. YING: Maybe we can pick, if we want we can pick one or two from there.

DR. MCCLELLAN: Okay.

DR. YING: Okay.

DR. MCCLELLAN: Koryn?

MS. RUBIN: Yes. So in regards to disease management is there maybe some kind of measures and I know you guys briefly discussed about cost shifting, but when you have possibly, you know, a medication that's prescription and then it's moved to over-the-counter, so the patient originally had a $10 co-pay and now they have to pay the full price of $30, $40, and now that's fully out-of-pocket where before there was some share in the cost.

And then in regards to

prescription limits where often the pharmacy benefit managers place limits, but like we know with eye drops in an elderly population they often exceed the limits within the month.

So if they need more prescription they have to pay the full price of the medication so that leads to, you know, the creative ways of managing their disease and often exasperating the disease where they now then will need, you know, some form of surgery where it could've easily been managed by medication if they had access to the right amount of medication.

DR. MCCLELLAN: Thanks. Jim?

DR. DUNFORD: Just a brief comment that some of the gaps that are identified in this family actually have been picked up by the Duals because a lot of patient and family centered care and prevention really is Duals, that's really what that work group, or task force, is really all about.

So, for example, we have

initiatives in smoking and alcohol and drug abuse and immunization, a number of these things. I wouldn't list them all, but just there's a lot of cross-pollination here.

DR. MCCLELLAN: Okay. Kevin?

DR. LARSEN: Yes. As I look at this area I think there is some potentially an NQF endorsed measure here we could put in that screening and brief intervention for alcohol use that does have good evidence from Wisconsin about decreased costs when you get people into alcohol treatment.

Actually it's about decreasing peoples use of alcohol before they end up with a diagnosis of alcoholism. And so, again, the costs are mostly societal costs and work related costs as opposed to being what we think of as healthcare costs.

But there are some healthcare costs decreases that have been shown with that particular measure.

DR. MCCLELLAN: Okay. So just in

a sense of I, let me see if I can try to get a sense of where we are, so we go back to the measures that we started with.

I didn't really hear a clear case for much in terms of the current CAHPS measures of a clearer link to impact on costs and to keep this report contained and enforceful, without that it's awfully hard to provide a recommendation.

Sticking with patient reports though, there are some very promising measures and some promising directions for further work including patient reported outcomes like control of disease, you mentioned asthma, diabetes, severe behavioral health issues, and patient reports about occurrence of adverse events.

I think those are, we talked about earlier, not well captured and maybe measures that get at secondary costs like school days missed, but more clearly a recommendation that from both surveys and CAHPS it should be

possible to get direct questions from patients and consumers about the affordability of their care.

So some of that's available now in surveys like MEPS, you know, percentage of income going to healthcare costs and people who are having trade-offs between using medical and other services, what other consumption they are foregoing.

Measures along those lines could potentially be incorporated in CAHPS. Similarly, while shared decision making is a goal there is not a lot of enthusiasm for the advanced care plan measure on the list either since it's just kind of, you know, does it exist and as Gerri was saying not much evidence that it actually does have an impact on cost.

So sticking with that standard I think we wouldn't endorse it explicitly, but measures of shared decision making, measures of whether a patient care plan was actually

followed in delivering care to a patient would potentially be relevant.

And with respect to health literacy, clearly associated with differences in costs, however, the evidence, at least as we've summarized it here, on how to reduce costs for particularly less literate, health literate patients, it really goes back to the coordination of care measures and having a less complex system to navigate.

We've covered a lot of those measures already in the care coordination section. Let me pause there, and I'm going to get to the prevention measures in a second, does that sound about right, yes?

DR. TERRY: Patient activation.

DR. MCCLELLAN: Yes, patient activation, too. I think it's a promising direction, but, again, not yet evidenced that it has an impact on cost.

So, you know, I think to the extent that this report can particularly flesh

out how these activities like patient engagement or, you know, better coordinated care, or impacts on health literacy could actually affect cost, that would be very helpful in hopefully guiding the further development of those measures. Yes, Nancy?

MS. FOSTER: So, Mark, I'm not sure I heard it in your summary, but I think there was some general support around the notion that while CAHPS is not a particularly helpful tool right now --

DR. MCCLELLAN: Right now, but it could be.

MS. FOSTER: -- it could be.

DR. MCCLELLAN: Absolutely. I think that may be the lead point is that it, you know, we do have examples in well done surveys of questions about affordability to, you know, individuals and patients.

So for now we can potentially use measures from those surveys about affordability that would be valuable, but the

aim should be incorporating that more directly in future versions of CAHPS.

With respect to prevention, for many types of preventative care, very good to do, important from a public health and quality of care standpoint, but less clear evidence on impacts on costs.

You all mentioned some potential exceptions though that probably are worth putting in a report. One is BMI, since obesity is associated with higher healthcare costs in the short term and we do have a good BMI measure.

A second is smoking cessation, the evidence there on healthcare costs impacts is less direct, but once again there are measures and at least some reason, and maybe we can check on this in our follow up, some reason to think that would lead to lower cost.

We also had an example of alcohol, drug abuse screening, and a brief treatment measure where we think there's some

connection, too.

I don't know if we can go forward to that slide, if there was anything else on the list where, you know, it does seem like there's this plausible and direct tie to cost we should probably, you know, while you're thinking about that I did leave out there are the health leads and community resource measures I think are worth mentioning, too.

There is, as Kevin mentioned, a good deal of validation, at least for high risk patients that doing assessments and addressing non-medical service needs like housing, food, and the like, can have a significant impact on healthcare costs, so I think that's worth including as well. Nancy?

MS. FOSTER: So behavioral health obviously an important area, I'm wondering if we can get started, Kevin, by looking at depression as a comorbid condition when a patient is in treatment for something else.

We know it occurs. We know it can

exacerbate costs, and at least if we were preventative --

DR. MCCLELLAN: But is there a measure of like, so it sounds like what we're getting at is treatment of depression as a comorbid condition --

MS. FOSTER: Yes. And I don't think there's a measure yet, but --

DR. MCCLELLAN: -- and is there anything we have on that? I don't think so.

DR. LARSEN: I'm right now --

DR. MCCLELLAN: Yes?

DR. LARSEN: It turns out NQF just endorsed 20-odd behavioral health measures in March and so I'm looking through the list right now and I don't see anything about a comorbid condition.

There's a whole suite though of depression and tobacco and alcohol measures here.

DR. MCCLELLAN: Good. Ron?

DR. WALTERS: I apologize again,

I'm a little bit of a visionary and I think we have a golden opportunity in front of us. In other NQF reports there's this very nice diagram that goes from the left hand side, population health, through prevention and screening, through an episode of care, through the post acute care, and you can carry it, you can break that down to as many levels as you want to.

And it shows, it's usually disease focused, so there's like, the one that's in the publication is cardiovascular disease, and it walks you through what kind of measures are available at the population level, what kind of measures might be available at the prevention and screening level, what kind of measures might be available that we end up talking about, mostly treatment related and complications of care and so on, et cetera, et cetera.

I think there's a wonderful opportunity, granted it's not even going to be

as built out as much of that, as that one is to link the results of this task force, affordability to that.

Because the concept that we're getting into now, that we all know is true, but there's a tremendous gap in knowledge, is that for some things it's a heck of a lot cheaper to avoid a problem than to treat it once it happens.

And the sorts of diagrams that exist there for conditions are a natural framework and we've kind of walked our way these last two days, we're getting to the left hand side now finally.

Now the trick is, of course, that in population health you don't know what you're talking about yet because you don't have a condition, you're just at risk for different things.

And so there is a little bit of a graphical problem there in portraying that, but some of the concepts that we've talked

about that are proven measures at a population health level could fit into that sort of graphical display and there could be a couple of examples that tie it into a specific area like, whatever, diabetes or cardiovascular disease, or something, to show conceptually the mode of thinking that we're going to.

DR. MCCLELLAN: Yes.

DR. WALTERS: The other thing that that might --

DR. MCCLELLAN: Would that work for obesity or, yes, that would?

DR. WALTERS: It'd work for, it probably would --

DR. MCCLELLAN: No.

DR. WALTERS: -- for a lot of things.

DR. MCCLELLAN: No.

DR. WALTERS: But the other thing it displays and the reason it's so important is all this care coordination we're talking about.

I mean that comes out just easily when you start looking at the hand-offs that have to occur and how the measures either support those hand-offs or, as we've spent a great deal of time talking about, sometimes don't support them because they don't exist when gaps exist.

So it's really more of a, just to put some thought, and, again, like I said I'm kind of a visual type person, into a one figure schema that shows kind of the thinking process that we went through in a lot of areas over the last couple days.

But this is the golden opportunity to do that and we aren't going to get a better one.

DR. LARSEN: One example for that might be Med Management. Because if you think about a key opportunity for saving money in adverse events and overuse and side effects, et cetera, is having a much cleaner Med Management and we're all actors in the Med

Management sort of framework.

MR. NELSON: Comment from Gene.

DR. MCCLELLAN: Yes, go ahead, Gene.

MR. NELSON: I'm thinking about what was said about the diagram with the at risk population on the left and once again the potential value of a rolled up measure of health risk, just if there's real value of a rolled up measure of harm.

And with respect to rolled up measures this is something that a group has been working on for a few years now for avoidable risk of death.

Chris Murray's group at the University of Washington that coordinates the global burden of illness work and a group from Dartmouth and more recently a group from Framingham have been working on validating for adults avoidable risk of death.

And the validation results are very positive. So either the Framingham Index

is one kind of risk index that's very helpful at both the population and individual level.

For example, when I see my internist periodically he will actually take out the Framingham Index values and coach me about what I can do to reduce my risk.

So if you take the Framingham Risk Index and then enhance it with, based on the rest of the data, the meta-analyses, for health behaviors there's a potential for a Framingham Index plus that gets at other behavioral variables that could be very helpful in the future.

DR. MCCLELLAN: Thanks. Yes, go ahead.

MR. NELSON: The overall avoidable risk of death statistics for predication are as good as the Framingham is for cardiovascular death and the Framingham group has validated the approach in their cohort, vis a vis a National cohort, so it's very promising for the future.

DR. MCCLELLAN: I've seen the validation of that measure and it is very promising. I guess in terms of this group I do want to try to keep the focus on yes, we've actually shown an impact on cost and, Ron, Gene, you guys are right, these are unquestionably good predictors of things that can, of foundations for preventing costly complications.

Unfortunately, it's still another step beyond that to be able to conclude that it's actually reducing healthcare costs as opposed to just, you know, increasing value from people living longer and better and there is certainly some components of these metrics like BMI that do have correlations with, you know, reducing healthcare costs in the short term.

So I think the framework sounds good. I think we probably want to call for, you know, sort of clearer links to cost saving as a criterion for including it in the

affordability group. Nancy?

MR. NELSON: Right. You're --

DR. MCCLELLAN: Sorry, go head, Gene.

MR. NELSON: I think I agree with what you just said, Mark. From an economic point of view the value of premature death or the cost associated with premature death to the community are --

DR. MCCLELLAN: Yes. It is tremendous, yes.

MR. NELSON: -- unknown and untabulated. And so in that sense there are, to the communities, to the employers, et cetera --

DR. MCCLELLAN: Right.

MR. NELSON: -- there are potential, very, very strong cost savings potential.

DR. MCCLELLAN: Right. And that is something, the secondary benefits are something that we do need to consider in this

section, too, thanks, or at least mention in the report. Nancy?

MS. FOSTER: Sorry, one other thought occurs to me, which Jim would be more able to expound upon if it's necessary, but did we make a mistake in leaving prevention of trauma off of here?

MALE PARTICIPANT: Yes.

MS. FOSTER: I'm thinking of car seats, bicycle helmets, those sorts of things.

DR. MCCLELLAN: And that gets back to your point about injury, too, yes.

DR. DUNFORD: Yes, and again that was, these data that were just presented by CDC this week on the five leading causes of death and what percentage of them were calculated to be preventable. And so probably, I don't know what, somewhere around 30 percent at least of trauma deaths are preventable.

And they list for all of five leading causes of death. Cardiovascular and

lung disease and the other things that we're talking about. Cancer.

DR. MCCLELLAN: Okay. Okay, if there's a metric there. Koryn?

MS. RUBIN: No, I'm fine.

DR. MCCLELLAN: Okay. Do you have what you need?

MR. SAUNDERS: I think we have what we need.

DR. MCCLELLAN: Okay, great. This was a wide-ranging discussion and I want to thank Allen and, well I guess I can't thank me for in-person, but I thank you guys for taking the time to help us through this and hopefully the discussion will also help connect further with the work that you're, the important work that you're doing.

Right, so we are onto our next and, this is the last section, right?

DR. DUNFORD: It is.

DR. MCCLELLAN: Well we got to wrap up, okay.

DR. DUNFORD: Yes.

DR. MCCLELLAN: Our last substance, I'm getting a little sad about that.

So this is an update on affordability projects across the NQF and their alignment with NQF's linking cost and quality measure, linking cost and quality with our group here.

So we've talked about, repeatedly, during this time the importance of not looking at affordability measures by themselves and the importance of us not viewing our job as coming up with measures for everything that you'd want to consider in conjunction with affordability.

But now is the time to think and talk more explicitly about how we do that together. And any contributions or thoughts that this groups has on the overall strategy.

So I think we're going to hear from Rob and Lindsey. Welcome. Oh sorry,

Chris.

MS. MORESELL: Ashley. I didn't --

DR. MCCLELLAN: Ashley.

MS. MORESELL: I'm a fill in for Lindsey --

DR. MCCLELLAN: Okay.

MS. MORESELL: -- so.

DR. MCCLELLAN: Okay. Ashley, very nice to meet you and we'll hear from you all about some of this other work that's ongoing and use that as a basis for our further discussion.

MR. SAUNDERS: Great. And so my colleague Ashley and I will sort of tag team this.

There's a portfolio projects ongoing at NQF really around this question of cost, resource use, affordability. This is in fact, there's five and this is one of those. And they sort of attack the question from different angles.

And so I thought, Ashley will sort of head up some of the ones really thinking about cost of resource use measurements, there are new measures for that. How we're thinking about linking cost and quality.

We'll also sort of talk about looking at affordability from the patient's perspective, which is another project we have ongoing.

And then there's very technical project thinking about how to construct episodes and episode groupers and we may just wave at that but just to note that there is a project there that has some impact on our technical ability to measure cost.

So why don't we just switch to here and I'll ask Ashley's indulgence to start us off maybe on the high level thoughts on our cost and resource use measurement and --

MS. MORESELL: Okay.

MR. SAUNDERS: -- maybe some initial reactions to our meeting last week

about linking --

MS. MORESELL: Sure.

MR. SAUNDERS: -- cost and quality.

MS. MORESELL: So should I start with the --

MR. SAUNDERS: Oh, you should feel free to start wherever you like --

MS. MORESELL: Oh.

MR. SAUNDERS: -- with high level thoughts and --

MS. MORESELL: Okay.

MR. SAUNDERS: -- we will go form there.

MS. MORESELL: So some of you actually in this room have been apart of our ongoing cost work. But we started, I guess, about three or four years ago in this cost measurement area.

Obviously NQF was kind of founded on quality measurement and performance improvement from the quality perspective and

we kind of moved into this cost space so it's reactively new for us. But we have been learning a lot.

And our first kind of endeavor into the cost measurement space was through cost measure endorsement project. We're now on our third or fourth project now and have a small portfolio of cost measures that are endorsed.

We're still learning a lot there and there's lots of challenges as you might think, as you might guess, about evaluating cost measures for various purposes. Particularly when it comes to payment and things like that.

And since then we have expanded our work to include efforts around trying to understand how to link cost and quality measures. Our first, I guess, consensus development project around endorsing cost measures, our committee was really uncomfortable with just focusing just on cost

measures.

We had always really kind of having started out obviously in the quality arena wanting to think about cost and quality together and how those two signals give us information about efficiency and value. And so the idea of just focusing on cost measures and endorsing cost measures made people very uncomfortable.

The challenge that we had was we didn't really know operationally if we were to look at cost and quality measures together like, what are we asking for, what are we asking developers for, how would we guide our committees to evaluate that, what are we endorsing.

And so without that work we were kind of sticking to what we knew around endorsement for the cost measures in hoping for an opportunity to really explore that issue.

So the fourth row down, the RWJF

project around linking cause and quality measures is really aimed at that. It's a piece of work we've been wanting to do for some time, to really explore what are some of the mythological challenges to combining cost and quality measures, what should we be thinking about as NQF as an organization if we're looking to eventually endorse efficiency measures or how does that fit into value.

And so we actually met last week actually, it seems like a lifetime ago. Last week we convened a group of experts here to talk about that. And it was a really interesting discussion.

We are commissioning a white paper with two authors, Chris Tompkins from Brandeis and Andy Ryan from Cornell or Weill Cornell thank you, to help us write that paper.

And they developed a draft paper for the committee to review and then we had the meeting, the two day meeting, to really discuss the foundational paper and figure out

how we're going to build upon that. And so that paper should be out hopefully in the next month or so with some recommendations on where we go from here with that.

You know, what is NQF going to be looking to do around efficiency and value measurement and where do we go in terms of endorsement in that space and what we potentially will be asking the development community and others to do with going further in that space.

In terms of implications for that work we're hoping that that will give our steering committees who are evaluating cost and resource use measures some further guidance on what to do as we continue to accept cost measures and should that be evaluated in the context of quality measures.

But also guidance potentially for some of the MAP work around how to, what are some considerations that should be included in the discussions around selecting measures for

particular programs that are looking at efficiency.

So hospital value-based purchasing another programs. What should the committee be thinking about when they're picking quality measures and cost measures to make recommendations for those programs.

In terms, should I keep going or --

(Off microphone comment.)

MS. MORESELL: Okay, I'll just quickly touch on the episode grouper work and how it kind of relates to some of the other things and then I'll hand it back over and take any questions if people have them.

We are continuing to do work around cost and resource use measure endorsement. We'll be meeting with our committee in June and hoping that some of the work from the linking cost and quality, from that paper will be ready for us to kind of feed back into that committee and see where we

go from there with this ongoing work as we have a standing committee.

In terms of the episode grouper evaluation criteria work, that work was really initiated from some legislation that came out awhile back around a public episode grouper that was legislated by the secretary for her to develop.

There was also language about a consensus body evaluating or endorsing that grouper and so our radars went up of course and we're like, oh gosh, we've never evaluated or endorsed an episode grouper, what does that mean, what is an episode grouper, what are we saying that we might potentially be endorsing.

And so this work was really to help us do some foundational work in thinking through, what do mean when we say episode grouper. And it think David was on that committee as well.

And so we, we're really trying to figure out definitionally, what do we mean,

how does this relate to other measurement systems. If we were to evaluate a grouper what exactly will we be evaluating, what criteria would we use, what will be endorsing.

And also to help us think through operationally for NQF. Like what are some things we need to be thinking about in terms of our process.

For those of you that are familiar with episode groupers they tend to have lots and lots of measures within them and they are very complex. And so that has a lot of implications potentially for how we do our work and what we would actually be evaluating if that were to be submitted to NQF.

So that's kind of where we are and happy to take any questions or --

MR. SAUNDERS: Sure.

MS. MORESELL: -- Rob, if you have anything to add.

MR. SAUNDERS: Why don't I jump in on the measure and affordability from the

patient's point of view and then will just --

MS. MORESELL: Sure.

MR. SAUNDERS: -- tag team from there?

MS. MORESELL: Sure.

MR. SAUNDERS: And so one of the last ones I just wanted to touch on was, and in addition to this link and cost and quality work, which we also did as sort of a parallel project looking at how to measure affordability from the patient's perspective, and we did that about a month ago.

And the goal was to really think about, very deeply, how do patients view affordability. And I think differently than some of our other meetings, we made sure that there were actual patients at the table.

In fact that there were how many six, you know, actual patients who came from outside of the D.C. proffer area to really think through this issue. Along with some of the more standard folks that we have around

this table, like clinicians and hospitals and insurance claims and the like.

And I think that was a useful meeting and can help inform some of this group just from a conceptual point of view because what we heard from the patients were that affordability didn't exist in a vacuum.

So yes, people looked at their out of pocket cost and that was, they had a number, they looked out of pocket cost divided by income and that was affordability.

But then they also factored in things such as, how inconvenient was my care. Did it involve having to miss work multiple times, because that work equals money. And how does this affect my family. How does this affect my quality of life. And that those issues sort of came to a broader perspective of affordability which I think were many of the themes that were brought up in this group over the last two days.

And so the reason we wanted to

make sure we highlighted these four other projects was that this group has been thinking about how to implement the MAP affordability family.

And we thought some of this work may be useful for, as this group starts to think through, how would this family be used in practice and where can we leverage what we've learned from these other NQF projects like say linking cost and quality, which was a theme that came up yesterday in I think all three breakout groups, into how we might use this family in practice.

So I guess, and now if folks have questions or comments or thoughts?

DR. MCCLELLAN: Yes any comments? I mean clearly these projects overlap with some of the next steps, especially measurement gaps, that we've proposed, you know, most recently in some of the measures in the last session on patient reported views about affordability of care. Kevin?

DR. LARSEN: Any ETA on the episode groupers, like when those are coming and when we could think about those being part of some measurement framework? Because they're appealing to put, as bands around cost and quality.

DR. MCCLELLAN: Well that's not the, this is not an actual evaluation grouper this is the criteria. But there's a lot of work, I mean there are a lot of measures that have been submitted already that relate to ETA groups and all that.

MS. MORESELL: Yes. So our last conversation with CMS, and obviously this has kind of been an anxiety producing issue for us as well.

Our last conversation, it's not that close actually. There's a lot of measures still in development. Probably a year or two off. I think there was some anticipation that it might come sooner, but I think now as their kind of getting into the

development of some of the additional condition-specific episodes that it's probably going to be at least a year.

DR. LARSEN: And just one of the, you know, word of caution from the trenches of the details, it's really easy to think at the description level that you're describing the same episode and then when you actual dive way down deep and realize that one measure was developed by NCQA and one by the Joint Commission and another one by the State of Minnesota, they actually have fairly different definitions of the orthopedic episode of care even though they say they're all talking about the same definition.

So we've been trying to find informatics ways to really be sure the specifications around things like denominators are as similar as possible. And that would be one of the things that we'd really highly recommend as we do this, that we're really, we work hard to leverage some consistent

definitions across a suite of related measures so they really are, the same people are in all the measures when we actually get to the end.

DR. MCCLELLAN: Nancy?

MS. FOSTER: Sorry, I'm just chuckling at the thought that same title of measures might be different. How unusual.

DR. MCCLELLAN: Yes.

MS. FOSTER: But what I was going to say really actually came from your comments and, Rob, your comments about the other organization, or the other groups works.

In particularly the work being done around affordability for the patients. Really terrific that you were able to bring in some real live patients to talk about their perceptions of it and I look forward to seeing that report because it will inform all of us.

But we sort of talked as if we were focusing on affordability to the patient. And I think in our hearts and minds that was the right place to go.

But as we went through things during the conversation I think we also touched on affordability at a wide variety of levels. As a nation, as a, you know, the payor, the employer, groups.

And so maybe there's a way to tease out in our report that we really need affordability at all of those levels and we need to be able to judge it at all of those levels. Which may be done by using similar measures or some of the same measures.

But there may also be other tools that are available to judge affordability at a national level like, you know, percent of GDP that aren't really relevant to the individual patient.

DR. MCCLELLAN: Thanks. You disagree, David, right? Yes, thanks.

All right, Ashley, thanks for the discussion and Rob. Thank you all for all the hard and challenging work going on to get us where we need to be. So now we can be even

more bold in our recommendations, right, about what needs to be, what needs to come forward. Thank you.

So our last kind of substantive discussion section is on conceptual guidance for applying the affordability family in practice. We're ready to move onto that?

MR. SAUNDERS: Sure, yes.

DR. MCCLELLAN: There are a few more slides with details of what we've just discussed, yes.

I don't think that's, so this is, you know, as we've just talked about and been talking about over the last couple of days, there are some real challenges. Not just in the measures, but in using these measures effectively to help improve decisions by individuals, by payers and purchasers, by policy makers.

And one of the things that we wanted to do to help wrap up the report is make sure we're highlighting important

considerations that we think need to be addressed in conjunction with using the affordability measures today and the improved affordability measures in the future that are the main subject of this report.

So in terms of these kinds of quality recommendations, we're not the first to go here, the NQF has previously highlighted, you know, most people here generally agree that it's not about cost or affordability measures by themselves but the cost and quality measures need to be aligned to truly understand value.

It also came up in the HFMA report that may be referenced over the last couple of days. And NQF is already clearly on record as supporting the use and reporting of resource use, cost and other measures in the context of quality performance measures. Preferably outcome measures.

And just looking at resource use measures alone doesn't provide an accurate

assessment of efficiency or value and can have undesirable consequences. This was also discussed recently at the Medpac meeting.

I think Rob you may touch, you want to touch on some of these issues as well. So this is just for context to put in place that there already is a lot of thinking and NQF related statements out there about how to use affordability types of measures. But I want to make sure this group has a chance to see if there's anything they want to add to that or particularly highlight.

MR. SAUNDERS: And I think, again, this group has already done some great work thinking about that. Especially in yesterday's breakout groups that it was interesting that each of the three independently came up with conceptual guidance about implementation and that helps the staff because now we can start to see some consensus that naturally emerged.

One of the things that came up and

we wanted to at least flag was there's an idea of balancing measures as well. And that's been brought up by Medpac about the idea of that many cost affordability measures are focused on overuse. And there maybe a need for balancing measures looking at under-use to make sure that we're sort of furnishing that middle ground.

And so we just wanted to make sure we at least highlighted that concept. Although that's not necessarily the only concept that this group may want to think about or bring up in talking about conceptual guidance for implementation.

Clearly these issues about linking costs and quality is something that's come up a lot and that ties into some of the other NQF work that's been done out there. But we wanted to make sure we brought up this Medpac work as well.

DR. MCCLELLAN: Great, so I see some cards up already so, Kevin, start with

you.

DR. LARSEN: So that, I think to add to the balancing, we've talked a lot about making sure the quality is a balancing measure.

The other word of caution I'll make, and this is from experience of doing kind of block grant capitation, is there is a certain brittleness to relaying on claims to measure efficiency. So what we found is that we were able to gain a lot of efficiencies in outcomes but that it was really hard to measure using claims when we did all sorts of new things.

So examples. When we could use care coordinators or community health workers that don't generate a claim. When we can do telephone calls instead of visits. When we can do emails instead of telephone calls or ER or ambulance runs.

There was a ton of efficiencies that we could build into the system. But a

claimed-based efficiency measurement couldn't see any of it. It just looked like there was no care.

And so I don't know exactly how to say that other then a word of caution and be really sensitive to the fact that relying on claims as the primary way to do this will not necessarily get us the results we want.

DR. MCCLELLAN: Thanks. And Davids, I'm not sure which one went up first.

DR. SEIDENWURM: The balance between overuse and underuse measures, there are some circumstances where we can define an appropriate rate of something, and so that can be combined in one metric, you know, as a range. And we've been discouraging people from doing that in the past because I think of the logistics of making the measurement and the purposes for which they can be applied.

But I think maybe as some of the data processing becomes more sophisticated and our knowledge improves, perhaps we can have

metrics that define appropriate ranges rather than just, you know, below this or above that.

MS. HASKELL: That sounds pretty scary. I'm thinking of things like appropriate range of C-section. I don't know, it just sounds scary.

DR. SEIDENWURM: Well, okay. I mean maybe that's, you know, I don't know the exact numbers for that. There are areas where I do know numbers. But, you know, you don't want the rate to be zero, right, but you don't want it to be 50 percent either, and I think there must be, you know, some optimum range.

Just like for cardiac surgery, I mean you want the rate to become low, but a zero rate would mean that you may be you know, weren't operating on some people that you could really help. Or maybe if a mammographer wanted to pass a recall rate that had a ceiling, then they would just, you know, call them all normal like the guy that just pleaded guilty in, was it southern California.

So I think a range may be, when we have the knowledge might be the way to go.

MS. HASKELL: I just think that would depend so much on provider skill. I mean again using C-sections that there would be providers who were capable of avoiding many more C-sections than some others.

DR. MCCLELLAN: David?

DR. HOPKINS: I was going to make a suggestion on framing this balance concept. It really popped out at me on the previous slide. Can we maybe have that back? Thank you, Mark.

DR. MCCLELLAN: This one?

DR. HOPKINS: Yes. So this is the traditional way of thinking is we spent all these years gathering data on quality and finally we've got some pretty good measures of quality but we're sure not all the way there yet. And now we're starting to come back to costs, and we're saying don't do cost without quality. Why isn't this a two-sided

recommendation?

We're in an era where the focus is or should be on value, so why isn't it, don't measure quality without cost and don't measure cost without quality? Two-sided. So I'd like to make that proposal for amendment.

And, you know, even on the next slide where it talks about balance, overuse, underuse, again we want to put equal weight on both.

DR. MCCLELLAN: Okay, with that any thoughts?

MS. FOSTER: I mean, seriously, it makes me nervous when we think about issues where you wouldn't do something that the patient could benefit from because of the cost.

DR. MCCLELLAN: I don't think that David was saying not do it, he was just saying, you know, have a measure so that you're aware of the cost implications.

DR. HOPKINS: We're talking about

these global measures of performance, right? Cost, quality, let's do them both.

DR. MCCLELLAN: Sean?

MS. FOSTER: Thank you.

DR. ADAMS: It was scary not only to you and Helen, but also to Congress when they didn't let comparative effectiveness research take cost into account. I don't know whether that straps us, but there is clearly a political view out there that it's a one-sided argument.

DR. MCCLELLAN: Don?

MR. MAY: Yes, I would agree about the concern of going too far, and I think watching that's going to be important. You know, I think in particular in a world where we're now moving into, you know, we've had health plans and payers being the check on physicians and providers, and actually I think patients wanting things.

So you've had that natural check and balance of the user versus the payer, and

the payer saying, you know, let's slow down, we're not going to cover this or we're going to pay less for this to provide incentives for use.

I think as we see providers now taking on more risk, the importance of, especially from the affordability context, when they're thinking about cost maybe as much as they're thinking about service, we do need to think about appropriate measures that start to look at underuse.

And I think whether there's stinting or whether there's delaying care, and because as we're learning what these episodes are, you know, what is efficient in a 30-day period may be inefficient in a 90-day period or a year.

And so I think developing -- and we've been trying to think a lot about what these measures might be, and having trouble so I'm actually very interested in looking at these.

But I think it's really important, especially as we have providers now going into more risk-based models where they're thinking much more about costs than they have in the past.

DR. MCCLELLAN: Any other thoughts? Sounds like a good opportunity for some thoughtful writing to capture the right balance and tone here.

DR. LARSEN: And I think that's where these episodes become really, really helpful, because then you can box this conversation into something where you can imagine a balancing measure of outcome, cost, underutilization.

I mean everything is just sort of squishy overlaps of possible squishy concepts and time intervals and people responsible. It's pretty hard to know that what you're changing in, you know, this half of a Venn diagram is the thing that actually changed that half of the Venn diagram when they only

have 20 percent overlap.

So having much tighter overlap, then I would be more confident about the two having a tight relationship.

DR. MCCLELLAN: Thanks. Sean?

DR. ADAMS: So as you're writing this report, what is the length between these, potentially these recommended and potentially implementable measures and the value-based purchasing program?

DR. MCCLELLAN: I don't think there's a direct link. I mean this report is about the measurement issues and there are a whole host of issues around linking measures into payment.

That said, if there is some sort of general guidance or thoughts that we want to include about how these measures would be implemented and used, I mean this would be the place to do it.

So, for example, this discussion we've just been having especially about as

providers are moving into more risk-based payment systems, it's important to include along with the measures of affordability or efficiency, some measures of potential underuse, you know, that would be kind of a general guidance principle, something like that.

Rob, do you want to add or clarify?

MR. SAUNDERS: No, I think that covers it. I think it hits the point of what the application in this family will be. And one of the hopes is that by creating this affordability family that's a pre-screened family that when it comes time to do pre-rulemaking and as they talk about value-based purchasing measures that then the MAP at that time can turn to this list and use that as an opportunity to move things along.

But it doesn't necessarily affect the program directly unless this group would like to make a particular description about

that.

DR. ADAMS: Well, the thing that strikes fear in the hearts of the providers, and I'll speak from that perspective, is that we have seen most attempts to measure quality and service turn into value-based purchasing entities. So we'll divide your HCAHPS with the five-year infection rates and we'll divide it into tertiles and do a reward-punish thing on that.

So the squishier and the greater number of these blunt elements come, the more you get this sort of tapestry of what quality is. And the fear for the providers would be that someone will pick and choose and start dividing any of those metrics into quintiles.

So we would want to encourage --

DR. MCCLELLAN: So this sounds like a different concern than sort of these balancing concerns, overuse, underuse, and cost and quality measures together that we've already talked about. This is about turning

measures that may not have been created for, say, ranking purposes into rank measures or something like that.

DR. ADAMS: Yes, so that has been the momentum on all the other ones, so we don't have any real reason to think this would be automatically immune unless we choose to state that early in the game.

DR. MCCLELLAN: I'm just trying to think of the best way to capture that. Because we do want to go forward with our measure recommendations, sort of caution about using them in areas where they haven't been tested or validated like for ranking purposes.

DR. ADAMS: Well, we would say something like, used in conglomeration they paint a picture of outliers or places to ask questions, is it too much here or is too little, but that taken individually they have, say, this nicer little value taken in as an individual metric.

DR. MCCLELLAN: Okay. I think

that kind of fits with the other themes. And this would be a good place to look at the --

DR. ADAMS: Right. So, you know, for example, the infection ones which are kind of easy. I mean those are imminently going to be paid by where you buy in those HII, HCAHPS same way. But they're pretty tangible, pretty reasonably tangible. But a lot of things that we have been talking about are not under the purview necessarily, or the person who they're attributable to. And so we have to be careful of whether we overstate that connection.

DR. MCCLELLAN: Kevin?

DR. LARSEN: Just a related idea we were talking about over lunch is that there is a tension between system measures and individual measures, and those could be individual to providers, individuals to hospitals, individuals to whoever as a sort of single entity.

And we often talk about these like they'll be easily applied in the same way

across all of those spaces, and it doesn't really work very well that way, to Sean's point.

That you can attribute to Kaiser a certain set of Care Coordination activities, but then we heard testimony from some of the Medicare Shared Savings independent practices that primary care doctors had direct control over five percent of the total Medicare spend for the Shared Savings Program that they were accountable for.

And so they had signed up and they're still going to do it, but the thing to realize is that's a really different lever than the lever that Kaiser has as an integrated health system with the health plan.

DR. MCCLELLAN: And in addition to that, measures that can even be calculated accurately and reliably for one level of providers can't be done at more microlevels too.

Okay, any other thoughts about the

report? And again there will be a chance to comment on this when the draft comes around too.

Jim?

DR. DUNFORD: Just taking that even back up to the population level, I think that the report has to send out and make the statement which is already obvious, which is that 80 percent of the determinant's health care costs are social determinants.

They're really, like you say, outside of the control of even a plan or a physician. That the attention really, ultimately, has to be directed upstream to the population based metrics and the integration across non-health services that are actually also we can share in.

I mean there are great savings to be had by better care coordination, for example, of mental health in the jails. And so there are enormous economies that we can have if we start looking toward nontraditional

partners.

And I think that the future will be to incorporate more people outside the box to come in here who are stakeholders in the final cost equation of this whole thing than, you know, assembling us who are health providers, because to a certain extent this is out of our control.

DR. DUNFORD: But possibly within in our control in nontraditional ways. I mean if you give someone an apartment, you know, a homeless person an apartment, their health care spending goes down and things like that. So it may be aspirationally something we could touch on.

DR. MCCLELLAN: Moving beyond the traditional scope of health care providers as you're doing in San Diego.

Any other final comments? Like I said, we are going to finish on time. I would like to turn now to the operator. Operator, can you check to see if there are any public

comments?

OPERATOR: If you would like to make a comment, please press star then the number 1. There are no public comments at this time.

DR. MCCLELLAN: Okay, thanks very much, operator.

Now the last item here is list a summary of Day 2 and next steps, and we've been trying to summarize as we've been going along so I'm not going to try to do a detailed recap now.

I would like to turn to Rob to talk about, Rob and team, to talk about what's next from here and then maybe spend a few minutes if there are any questions about that or anything else that you'd like to make sure we do summarize or at least get on the table before we move forward with the rest of this process.

MR. SAUNDERS: Sure. And I'll talk sort of broad conceptually and I'll ask

my colleague Erin to help me with some of the timeline dates as well.

But from here the staff will go back and we're going to huddle up in the next few days to analyze our notes and make sure we're pulling out the broad themes that have come out here. We're also collaborating with the other two families as we're putting out this report together on putting out a joint product, and we'll certainly work with them and share with them what we've talked about in these few days and also make sure that we can benefit from what they've learned.

And then this report will go out for public comment and then we will eventually have a final report relatively quickly.

Erin, would you mind talking through what the timeline is for those steps now? Just sort of when are we going to have a report ready for public comment and when do we need to have this done?

MS. O'ROURKE: We're hoping to

have the report available for public comment June 2nd. We don't think we'd be able to get the task force an advanced copy, but if you have comments on that we can incorporate your comments at the same time as the public comments and bring that to the coordinating committee, I believe, the week of June 20th to turn the report into HHS July 1.

MR. SAUNDERS: So with a relatively short turn around in all these steps. But we want to make sure that we hear from you and we'll make sure we keep you informed as public comment happens and as we move to the coordinating committee as well.

MS. FOSTER: Rob, I'm not sure I understood. Is it one report for all three of the groups?

MR. SAUNDERS: That's right.

DR. MCCLELLAN: Do you want to say a little bit more about how that all is going to come together or maybe you're working on that now.

MR. SAUNDERS: So there's some magic. And the hope would be that each of three families are putting together a short brief about their particular family, so a few pages, and then we'll draw at key themes that seem to stay in the families.

And as we've discovered today there are some key themes that seem to cross lines, and especially in terms of gaps but also in terms of just where the task forces would like the field to go, and there's some clear sort of opportunities that overlap.

So that's the hope although we hope that we'll have a product that we can pull out to show here's what the affordability family looks like, and be able to share that more particularly with others but to have an integrated product that we need to turn in to HHS.

DR. MCCLELLAN: Other questions or comments? All right. So please do look for that report coming. Sounds like June 2nd is

a firm date.

MS. O'ROURKE: Should be fairly firm. I think that's as late as it can go.

DR. MCCLELLAN: And there's been a very rich discussion. They're all very challenging issues but they're critical ones, and I appreciate a lot of different perspectives around the table. I appreciate how constructive everybody was in trying to find an effective path forward for recommendations.

I'm sure the NQF staff is going to do the best job they can in trying to capture all of this, but if you see the report on the 2nd and it doesn't capture everything perfectly just keep in mind there is still time to revise and make sure any critical issues do get addressed, and I'll be available along with Rob for any follow-up on major questions you might have.

In the meantime, I think there are a few issues where staff may want to get back

to you about specific measures that you referenced or projects or evidence related to points that are important for the report, so thanks in advance for being available for that as well.

And mostly thanks for all the time and effort on this issue, both all of you who are members of this committee and especially the NQF staff who I know have had to put in a ton of time already putting this together, and I don't envy your next few weeks either. So thank you all very much.

(Applause.)

DR. HOPKINS: And thanks to our chair.

(Whereupon, the meeting in the above-entitled matter was concluded at 2:10 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: Map Affordability Task Force Meeting

Before: Chair Mark McClellan

Date: Thursday, May 8, 2014

Place: NQF

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