

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:

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Measurement

JOANNE CONROY, MD, Association of American
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HELEN HASKELL, MA, Mothers Against Medical Error

APARNA HIGGINS, MA, America's Health Insurance
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EUGENE NELSON, MPH, DSc, Population Health*

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* present by teleconference

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

2 8:38 a.m.

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

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

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

22 And I think there are some really

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

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

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

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

1 together.

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

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

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

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

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

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

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

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

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

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

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

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

22 Are there, as we talked about

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

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

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

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

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

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

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

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

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

1 to roll it all up and that makes sense.

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

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

10 Nancy?

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

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

22 The work of this group is around

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

4 CHAIR McCLELLAN: Good. Sean?

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

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

22 DR. MULDOON: Well in terms of

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

7 CHAIR McCLELLAN: Joanne?

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

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

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

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

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

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

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

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

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

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

8 CHAIR McCLELLAN: David?

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

11 CHAIR McCLELLAN: I took mine
12 down.

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

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

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

1 happening?

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

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

12 Beth?

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

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

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

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

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

15 You do have a measure that's the
16 total spending. And there are some measures,
17 I guess they're not endorsed, but measures
18 that use -- that we talked about yesterday,
19 that use standardized pricing.

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

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

5 Do you all have something like
6 that, or?

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

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

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

1 and others who might want them.

2 Jennifer?

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

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

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

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

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

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

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

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

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

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

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

13 CHAIR McCLELLAN: All right,
14 thanks. Kevin again.

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

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

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

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

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

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

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

1 with often a reference.

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

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

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

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

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

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

16 Aparna?

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

1 discussion.

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

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

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

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

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

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

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

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

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

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

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

1 the functionality that's built into those
2 tools.

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

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

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

22 And so the report actually talks

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

8 CHAIR McCLELLAN: Okay Jim?

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

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

22 Number two is you know, one thing

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

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

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

21 MR. MAY: No, that's fine.

22 CHAIR McCLELLAN: the meeting got

1 started and Don is here.

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

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

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

1 this information to patients.

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

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

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

1 very difficult I think for providers to do
2 this.

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

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

12 CHAIR McCLELLAN: Thanks Don.
13 David?

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

22 And also, I think if we could try

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 different identifying codes.

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

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

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

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

22 I maybe ask not to put you on the

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

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

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

1 charge master.

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

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

16 CHAIR McCLELLAN: Peg?

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

1 transparency issue.

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

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

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

1 on how to do that.

2 So those are my -- my thoughts.

3 CHAIR McCLELLAN: Thank you. Wei?

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

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

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

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

1 range, but we have to stick with that range.

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

9 CHAIR McCLELLAN: Okay, thank you.
10 Nancy?

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

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

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

6 CHAIR McCLELLAN: I've heard that
7 before.

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

16 CHAIR McCLELLAN: Okay. Good
17 questions. Aparna?

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

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

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

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

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

22 Some of the studies are actually

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

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

10 CHAIR McCLELLAN: Thanks. Joanne?

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

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

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

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

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

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

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

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

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

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

22 MS. HIGGINS: Well, so sorry, I

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

2 CHAIR McCLELLAN: No, go ahead.

3 No, that's all right, if you want to feel
4 compelled.

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

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

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

22 MS. HIGGINS: But I don't know if

1 that's what you meant, so.

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

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

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

1 know plugging it into the wall.

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

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

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

17 David?

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

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

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

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

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

22 CHAIR McCLELLAN: Yes. So episode

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

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

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

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

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

1 definition from the HFMA report. Rob, it's a
2 --

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

7 From the HFMA report, just to read
8 it very quickly, the price -- they define
9 price transparency as in healthcare, readily
10 available information on the price of
11 healthcare services that together with other
12 information, helps to define the value of
13 those services, and enables patients and other
14 care purchasers to identify, compare and choose
15 providers that offer the desired level of
16 value.

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

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

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

3 Helen?

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

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

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

18 CHAIR McCLELLAN: Okay.

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

22 CHAIR McCLELLAN: Thank you.

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

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

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

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

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

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

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

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

20 CHAIR McCLELLAN: Aparna?

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

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

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

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

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

1 think we're one more.

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

7 CHAIR McCLELLAN: Thanks. Wei?

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

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

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

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

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

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

19 DR. YING: Yes, to start. Yes.

20 CHAIR McCLELLAN: Okay. David?

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

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

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

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

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

1 and so on.

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

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

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

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

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

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

7 DR. DUNFORD: And patients rarely
8 tip.

9 DR. SEIDENWURM: With respect to
10 the out of pocket versus cost, I mean that's
11 a really interesting issue. I'm persuaded by
12 the stewardship issue. Because we, you know
13 just by my own experience, we self insured for
14 an employer group of I think it was about
15 1,200 employees.

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

1 know, benefit design aspects of it as well.

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

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

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

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

22 And we won't get there unless we

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

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

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

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

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

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

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

14 Nancy?

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

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

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

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

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

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

18 CHAIR McCLELLAN: Okay. Aparna?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 that you're in and the services you want.

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

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

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

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

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

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

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

14 Any thoughts? Beth?

15 DR. AVERBECK: One thing we could
16 take a look at so the cost by procedures, ADA
17 counter procedures, lab pathology, some
18 imaging, some office visits, and that's about
19 88 procedures. So that's one option. And we
20 can certainly -- I can take that back and see
21 if we wanted to submit that.

22 So that's kind of the menu option.

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

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

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

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

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

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

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

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

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

15 David?

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

20 CHAIR McCLELLAN: Sorry, remind me
21 of them.

22 DR. HOPKINS: So I mean just to

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

5 CHAIR McCLELLAN: Oh, right.

6 DR. HOPKINS: Remember that one?

7 CHAIR McCLELLAN: Yes.

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

10 CHAIR McCLELLAN: Yes. So, so --

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

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

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

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

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

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

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

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

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

10 CHAIR McCLELLAN: Were you going
11 to say something?

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

14 CHAIR McCLELLAN: Helen?

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

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

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

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

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

17 CHAIR McCLELLAN: You want to take
18 that?

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

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

1 plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MS. HIGGINS: Well, yes I think we

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Kevin?

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

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

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

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

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

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

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

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

1 -- total cost of care type measures for
2 providers.

3 Were you going to say something,
4 or?

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

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

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

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

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

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

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

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

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

1 good framework for moving forward.

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

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

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

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

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

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

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

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

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

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

7 And I'm not sure what page we're
8 on if you're following along in your guide.
9 31? Okay. So go to page 31 is you want to
10 see what's on the screen right in front of
11 you.

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

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

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

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

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

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

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

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

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

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

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

20 So I think I'll stop there.

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

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

7 Yes, Nancy go ahead.

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

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

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

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

6 CHAIR McCLELLAN: Okay, Gerri?

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

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

22 And utilization is actually one of

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

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

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

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

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

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

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

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

21 CHAIR McCLELLAN: Yes.

22 DR. LAMB: I'm trying to remember

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

4 MR. SAUNDERS: That sounds
5 accurate for it.

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

11 CHAIR McCLELLAN: Yes. David?

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

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

1 measures today.

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

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

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

19 CHAIR McCLELLAN: Thanks. Helen?

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

1 hospitals and care coordination.

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

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

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

22 And we have struggled and

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

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

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

1 seeing them?

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

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

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

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

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

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

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

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

22 DR. THOMAS: So one of the

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

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

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

20 CHAIR McCLELLAN: Thank you.

21 David?

22 DR. SEIDENWURM: Well, two things.

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

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

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

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

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

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

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

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

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

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

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

11 CHAIR McCLELLAN: Very impressive.
12 Peg?

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

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

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

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

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

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

21 CHAIR McCLELLAN: Atrius?

22 DR. TERRY: Atrius, yes, the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 CHAIR McCLELLAN: Joanne?

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

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

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

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

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

1 metric.

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

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

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

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

1 going to be used.

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

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

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

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

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

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

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

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

11 MR. SANCHEZ: We can pull those
12 up.

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

16 DR. HOPKINS: Like admissions for
17 CHF, right?

18 CHAIR McCLELLAN: Yes.

19 DR. HOPKINS: We should end it.

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

22 UNKNOWN: Asthma too, I think was

1 there. We looked at these yesterday in
2 utilization.

3 CHAIR McCLELLAN: Okay. Nancy?

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

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

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

22 The second thing, not that I've

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

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

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

20 CHAIR McCLELLAN: Very good
21 question. Beth?

22 DR. AVERBECK: Just wanted to

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

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

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

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

19 CHAIR McCLELLAN: Thanks. Jim?

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

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

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

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

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

22 And the goal would be to actually

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

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

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

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

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

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

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

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

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

1 going, how often those feeds are occurring.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 CHAIR McCLELLAN: Thanks. Aparna?

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

10 CHAIR McCLELLAN: We are having
11 the gap discussion.

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

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

1 does it for example.

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

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

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

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

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

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

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

12 CHAIR McCLELLAN: So any more
13 specific --

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

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

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

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

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

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

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

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

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

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

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

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

1 do this in any number of different ways.

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

7 CHAIR McCLELLAN: Thanks. Peg?

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

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

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

22 And end of life care does hit that

1 very high cost area. And I know there are --
2 there a lot of ways people are trying to
3 improve it. And we're you know, palliative
4 care teams and hospitals, you know, working
5 with patients, trying to make decisions early.

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

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

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

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

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

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

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

22 One other that I just wanted to

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

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

11 Gerri?

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

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

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

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

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

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

1 domains.

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

7 CHAIR McCLELLAN: Great. Thanks.
8 Joanne?

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

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

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

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

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

15 CHAIR McCLELLAN: David?

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

1 measure development.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 CHAIR McCLELLAN: Right. Okay, so

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

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

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

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

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

1 Camden?

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

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

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

22 And so when we knew that, wall of

1 a sudden we could really change our
2 expectations about how we scheduled
3 appointments and we were no longer having an
4 80 percent fail rate in the before 9:00 a.m.
5 Because there was a kind of structural market
6 segment issue with the people living in
7 poverty not wanting to take high cost bus
8 trips to the doctor.

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

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

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

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

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

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

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

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

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

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

16 Good. Good work guys. So we're
17 schedule to restart at 11:00. If we run a
18 couple of minutes late, let's say 15 minutes,
19 11:05 for starting again. Okay, thanks.

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

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

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

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

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

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

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

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

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

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

22 And we had as Mark says, most

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

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

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

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

20 So, let me turn that back.

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

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

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

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

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

18 David?

19 DR. HOPKINS: Can you --

20 CHAIR McCLELLAN: The three
21 pressure ulcer measures, or

22 DR. HOPKINS: The three not

1 selected.

2 CHAIR McCLELLAN: The three not
3 selected, okay.

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

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

14 MR. SAUNDERS: Sure. So for those
15 three, so 337, the pressure ulcer rate, the
16 numerator is the percent of discharges.
17 Basically among cases where they've done ICD
18 9 code, about pressure ulcer.

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

1 at any sort of surgical or medical discharges.

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

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

13 So those were those three.

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

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

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

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

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

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

18 CHAIR McCLELLAN: Yes.

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

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

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

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

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

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

4 (Audio interference)

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

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

1 competence for conditions like stroke I think,
2 right?

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

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

16 CHAIR McCLELLAN: Rather than by
17 type specific error?

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

1 that's how the department's organized.

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

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

20 CHAIR McCLELLAN: Did you have
21 something else on this?

22 DR. CONROY: Yes. Just another

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

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

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

20 CHAIR McCLELLAN: Yes. Wei?

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

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

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

7 (Audio interference)

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

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

12 Nancy?

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

17 (Audio interference)

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

1 there's costs here

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

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

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

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

21 CHAIR McCLELLAN: Okay.

22 MS. FOSTER: Just to add to that -

1 -

2 (Audio interference)

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

6 MS. FOSTER: And along those
7 lines, --

8 (Audio interference)

9 CHAIR McCLELLAN: Sean?

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

12 (Audio interference)

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

20 So this is probably a case where
21 014, the science and evolution -- the
22 definition is -- probably pretty inconsistent

1 with the other two metrics.

2 CHAIR McCLELLAN: Helen?

3 MS. HASKELL: Just a --

4 (Audio interference)

5 DR. THOMAS: You mentioned

6 yesterday about the value of (Audio

7 interference)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Andy thoughts from here, or
12 further discussion?

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

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

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

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

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

17 Nancy?

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

1 expenditures as well as harm to patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 David?

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

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

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

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

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

1 utilization rate.

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

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

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

22 Jennifer?

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

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

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

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

1 acquired infections.

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

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

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

20 Helen?

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

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

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

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

10 MS. HASKELL: It's a PSA.

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

13 MS. HASKELL: Is it endorsed?

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

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

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

22 MS. HASKELL: Maybe we need to

1 measure on the accuracies of hospital billing.

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

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

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

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

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

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

19 MS. HASKELL: It will help.

20 CHAIR McCLELLAN: Not immediately
21 probably.

22 MS. FOSTER: Right. It will still

1 be an adjustment period. We believe that a --

2 CHAIR McCLELLAN: Microphone.

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

7 DR. NELSON: Comments from Gene.

8 CHAIR McCLELLAN: Yes, Gene go
9 ahead.

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

17 Specificity 85 percent.

18 Predicated value positive 59 percent.

19 Negative Predicated value 88 percent.

20 Concordant 75 percent. And what we concluded
21 and recommended was that was a good measure
22 for use within hospitals over time for

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

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

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

20 CHAIR McCLELLAN: Kevin?

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

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

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

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

22 And those actually work really

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

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

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

16 CHAIR McCLELLAN: Thanks. Nancy,
17 yes.

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

1 complication during a calendar year.

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

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

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

13 CHAIR McCLELLAN: Quite broad.

14 MR. SAUNDERS: Right.

15 MS. FOSTER: It does.

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

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

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

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

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

1 impact on cost and affordability. There's
2 some problems with --
3 (Audio interference)

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

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

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

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

1 who may not have worked with you before.

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

8 CHAIR McCLELLAN: Um-hum.

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

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

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

16 CHAIR McCLELLAN: Uh-huh.

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

1 service.

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

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

14 CHAIR McCLELLAN: Thank you.
15 David?

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

22 CHAIR McCLELLAN: Yes. Sorry, I

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

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

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

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

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

4 CHAIR McCLELLAN: Thanks. Helen?

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

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

18 MS. HASKELL: Well, and you know -
19 -

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

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

5 But that's certainly open for
6 further discussion.

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

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

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

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

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

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

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

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

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

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

22 So when our measure we looked at

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

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

12 That becomes a major cost driver
13 for the newborn baby.

14 CHAIR McCLELLAN: Thank you. Ron?

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

22 Because we don't have any

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

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

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

14 CHAIR McCLELLAN: Ron?

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

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

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

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

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

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

22 CHAIR McCLELLAN: Well just a

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

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

14 But, oh David, good, go ahead.

15 Well, we are trying to wrap up,
16 so.

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

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

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

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

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

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

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

1 Is something like that approach?

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

10 MR. SAUNDERS: Let me just to
11 repeat.

12 CHAIR McCLELLAN: Um-hum.

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

19 CHAIR McCLELLAN: Joanne?

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

1 it's uncommon. It's important, but it's
2 uncommon if we're talking about affordability.
3 That really would belong more in complication
4 conversation, not linked to affordability, so.

5 CHAIR McCLELLAN: Is it any less
6 common then wrong site? So maybe an
7 intermediate step would be a comment that
8 those two in particular are quite rare, and
9 probably are not -- yeah. Probably are not
10 going to be big predictors of cost.

11 And again, I think that fits with
12 the theme of getting to or roll up measure
13 that is a better overall predictor of cost and
14 safety.

15 Nancy?

16 MS. FOSTER: So I'm not crafting
17 your roll up measure for you, but because they
18 are similarly infrequent, I would think that
19 363 and 267 aren't driving costs.

20 CHAIR McCLELLAN: Yes. That's
21 what we were just talking about is an
22 intermediate way of handling this.

1 MS. FOSTER: That's affordability
2 in the general. Which is not say taken out of
3 the safety family, but it says if you're
4 looking for affordability, this isn't going to
5 get you very far down the road.

6 CHAIR McCLELLAN: Aparna? Oh,
7 sorry, did you have another comment?

8 MS. FOSTER: Yes, I did. And I'm
9 -- I'm going to say this. Please, please
10 understand I don't mean it as bluntly as I'm
11 about to say it. But I think there's a danger
12 in including some of the measures like Helen
13 let me take it up on the failure to rescue.
14 One might actually in looking at cost find
15 that death was less costly then maintaining
16 the life of that patient who obviously had
17 something very seriously wrong with him to
18 begin with.

19 And so I am not speaking to taking
20 these things out of the safety bucket. That
21 that's not our purview for today and I'm not
22 talking about that. But in terms of

1 affordability, I just raise the caution that
2 we may have some perverse things happening if
3 we're including some of these measures in
4 affordability.

5 MS. HASKELL: Well, I think some
6 of these things, I mean the point of that
7 measure is unexpected deaths of the patient,
8 did not have something seriously wrong with
9 them originally. So the idea is that this was
10 a hospital acquired a condition.

11 It's an unexpected death right?
12 Am I thinking of the wrong measure?

13 MS. FOSTER: Failure to rescue
14 means that they had something very seriously
15 wrong with them that would have required a
16 rescue.

17 MS. HASKELL: Right, but --

18 MS. FOSTER: And someone failed to
19 rescue them.

20 MS. HASKELL: The measure I'm
21 thinking about, I don't want to get too much in
22 to -- the measure I'm thinking of is

1 unexpected deaths in a post-surgical patient,
2 which you know, indicates that from a
3 complication, that they wouldn't -- you know,
4 so the complication was hospital acquired and
5 was not recognized.

6 CHAIR McCLELLAN: I do think it's
7 helpful to make the distinction between the
8 purpose of as you were implying, the purpose
9 of the safety family, which is about safety,
10 and the purpose of the affordability family,
11 which is about cost.

12 And as we've said from the
13 beginning, is not meant to be looked at in
14 isolation from quality and other measures. So
15 you know we -- this may be a little bit
16 difficult to finesse, and it may be something
17 we can come back to in comments on the actual
18 report.

19 But I think if we can put that
20 comment up first, then --

21 MS. HASKELL: Well, I mean you
22 know, I think things like that are a major

1 cost driver.

2 CHAIR McCLELLAN: Right.

3 MS. HASKELL: Because that's like
4 people in the --

5 CHAIR McCLELLAN: Right, that's
6 right, if it is a major cost driver, then
7 that's the kind of thing that would be
8 included here. If it's not, then it would be
9 less important and then that leads into our
10 kind of weighted roll up measures that predict
11 safety issues at a systemic level.

12 MS. HASKELL: So you give someone
13 going in for a minor procedure and they end up
14 in ICU for 30 days or --

15 CHAIR McCLELLAN: Right. And so I
16 think what we'd ask the staff to do is try to
17 do the best of a pass they can at what's the
18 evidence that some of these safety measures
19 really do predict higher costs and those would
20 be the ones that we particularly want to
21 emphasize for this group.

22 Aparna?

1 MS. HIGGINS: So I --

2 CHAIR McCLELLAN: Microphone.

3 MS. HIGGINS: I would agree with
4 that Mark, and I just want to -- and I think
5 on some of these things, and I don't know what
6 the evidence is obviously, and staff's going
7 to do some work, but.

8 You know, so for example with --
9 you could have you know, low frequency, high
10 cost events. And I don't know how much of
11 these fall into that bucket. Obviously so I
12 think that remains to be seen.

13 But for example with you know,
14 something like wrong site, wrong side, I could
15 see it's not just the direct cost but indirect
16 cost for example. And I know we talked about
17 this yesterday. So some of the down stream
18 effects which are not necessarily captured.

19 So it would be you know, so if
20 somebody cut off my right arm instead of
21 something else, then you know, now I'm looking
22 at loss of wages and all these other effects.

1 So I think you know, it also depends upon sort
2 of other indirect impacts as well, so.

3 CHAIR McCLELLAN: Thanks. Jim?

4 DR. DUNFORD: I was just going to
5 us as an example that there's a report from
6 HHS yesterday that came out that reports, this
7 is the kind of thing that as a customer --
8 consumer you're going to be reading you known
9 new HHS desk shows major strides in patient
10 safety leading to improved care and savings.

11 And so they have their ventilator
12 associated pneumonia, early elected delivery,
13 OB trauma rate, venous thromboembolism, falls
14 and trauma and pressure sores. And that's a
15 nice --

16 CHAIR McCLELLAN: Well those are
17 all pretty common.

18 DR. DUNFORD: Yes, that's a nice
19 package that people can look at and they can
20 associate that with X \$4.1 billion reduction
21 in costs. So I think that that's what -- I
22 think you need specific examples.

1 And then some of the aggregate
2 ones I think also put it in context for the
3 other issues. But I think it's important to
4 have some of these broken out as they are.

5 CHAIR McCLELLAN: Okay. We have a
6 little bit of work in editing. So remember
7 you're going to get another crack at this when
8 it comes back around.

9 All right, I think we're at a
10 point now where we need to ask about public
11 comments. So operator if you're on with us,
12 could you open up the lines.

13 OPERATOR: Please respond to make
14 a comment please press star then the number
15 one. There are no public comments at this
16 time.

17 CHAIR McCLELLAN: Okay, thanks
18 very much operator. And that means we are now
19 breaking for lunch. So we've got 30 minutes
20 until 12:30 when we're going to start back
21 with a segment on alignment with a work of the
22 MAP population health and personal family

1 centered care, task forces and measure
2 selection and gap identification for mis-
3 prevention opportunities and person and family
4 centered care.

5 God, I got that all out in one
6 voice. This is -- this really about -- this
7 is going to include a lot of discussion around
8 person reported measures.

9 So put on your thinking hat for
10 that topic. I know it's come up in some of
11 our previous discussions. But we're going to
12 try to talk about caps, measures, other
13 related patient reported measures too. Okay.

14 (Whereupon, the above-entitled
15 matter went off the record at 12:00 p.m. and
16 resumed at 12:30 p.m.)

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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

1 Allen and Mitra with us today. I'll ask you
2 all to introduce yourselves as you start your
3 walkthrough of some of the work that your task
4 forces are doing.

5 Just as an up-front comment, there
6 are not any specific measures from the
7 prevention family, at least so far, that we
8 see as clearly related to the cost, but I know
9 there's going to be some good discussion
10 around that.

11 And in the patient-centered family
12 there are some opportunities as well, mainly,
13 as I mentioned earlier, related to CAHPS, but
14 perhaps some other areas, too.

15 So, Rob, any other intro comments
16 for this section?

17 MR. SAUNDERS: No, and just real
18 quickly, I think just like the previous two
19 sessions where we've talked about aligning
20 this work with previous families on care
21 coordination and safety. The goal is here is
22 to think about their work, which is really

1 diving into what are the important population
2 health, or what are the important patient- and
3 family-centered care issues, and then take in
4 an affordability lens to it.

5 And all three of our families will
6 be in the same report, so it will be important
7 to make sure that we're aligned on the
8 measures that are identified in these areas.
9 And that's it.

10 DR. MCCLELLAN: Okay, great. So
11 who's up first?

12 MR. SAUNDERS: We'll do Person
13 and Family Centered Care.

14 DR. MCCLELLAN: Okay.

15 MS. GHAZINOUR: Good afternoon,
16 everyone. My name is Mitra Ghazinour. I am
17 a Project Manager supporting the MAP Person
18 and Family Centered Care Task Force.

19 And, so, similar to the
20 Affordability Task Force, this task force
21 convened in March to identify the high-
22 leverage opportunities and measurement areas

1 to promote person- and family-centered care.

2 So this task force is focusing on
3 the NQF's priority of engaging patients,
4 engaging persons and families as partners in
5 their care. And also focusing on advancing
6 the goals of this NQF priority, which is to
7 improve the experience of persons, families,
8 and caregivers, improve their experiences of
9 care. And also encouraging partnership
10 between persons, families, and caregivers in
11 developing care plans that incorporate their
12 preferences, values, and goals. And, lastly,
13 to empower persons and families to be able to
14 manage and coordinate their own care.

15 So the Task Force defined --
16 actually this definition, we have other NQF
17 projects that are also focusing on this
18 topical area, and this definition has evolved
19 and has been developed through other work at
20 NQF, with Kevin Larsen also leading that work.
21 It's called Measure Gaps: Person-Centered Care
22 and Outcomes.

1 So we have been using that
2 definition in order to be aligned, our
3 recommendations to be in alignment. So
4 person- and family-centered care is defined as
5 an approach to the planning and delivery of
6 care across settings and time that is centered
7 around collaborative partnerships among
8 individuals. They are defined family and
9 providers of care and it supports health and
10 well-being by being anchored by, respectful
11 of, and responsive to an individual's
12 preferences, needs, and values.

13 And so according to this
14 definition. and as I discussed NQF's priority
15 and goals, the Task Force identified four
16 high-leverage opportunities of experience of
17 care, quality of life, and patient and family
18 engagement, and lastly, but not the least,
19 access to self-management support.

20 The experience of care includes
21 measurement areas of dignity, respect,
22 compassion, and equity for all people, all

1 persons receiving healthcare. Care
2 integration, which will include care
3 coordination and care transitions. And also
4 provider communication and collaboration.

5 Quality of life is a broad concept
6 which could entail all these measurement
7 areas, including functional and cognitive and
8 mental health assessment and improvement,
9 physical, social, emotional, and spiritual
10 support and well-being, symptom and symptom
11 burden and treatment burden.

12 And also the Task Force deemed
13 patient and family engagement as a high
14 priority for measurement, which entails
15 establishment and attainment of patient and
16 family caregiver goals, shared decision-
17 making, advanced care planning that expands
18 beyond end of life care planning and includes
19 care planning for people with multiple chronic
20 conditions and complex illnesses. And also
21 care that is in concordance with individual
22 values and preferences.

1 And so the last one is access to
2 self-management and support which includes
3 patient activation, health literacy, cultural
4 and linguistic competency, and caregiver needs
5 and supports.

6 And so the Task Force will convene
7 this Monday via an in-person meeting to
8 identify measures and high priority gap areas
9 regarding these high-leverage opportunities
10 and measurement areas.

11 That concludes my presentation.
12 Thank you.

13 DR. MCCLELLAN: Great. Thanks
14 very much, Mitra, and I think are we now going
15 to preventions?

16 So we are going to have plenty of
17 time for discussion, but if there are any
18 clarifying questions now --

19 MS. RUBIN: Yes. How does this
20 relate to all the other NQF work going on
21 around, you know, linking cost and quality,
22 cost and resource use, you know, and the

1 evaluation that MAP is doing in affordability
2 space --

3 MR. SAUNDERS: That's the next
4 session, so we'll have time.

5 DR. LEAVENS: Great. I'm Allen
6 Leavens, the Senior Director in Strategic
7 Partnerships at NQF. And we actually had both
8 a web meeting and an in-person meeting for the
9 MAP Population Health Task Force, which
10 similar to Patient and Family Engagement and
11 the Affordability Task Forces, we discussed
12 high-leverage opportunities for population
13 health improvement based on the National
14 Quality Strategy goal of working with
15 communities to promote wide use of practices
16 to enable healthy living.

17 And what's a little unique about
18 this priority area is that it focuses much
19 more on health rather than healthcare. And if
20 you look at the long term goals specified in
21 the National Quality Strategy, you can see an
22 emphasis on social, economic and environmental

1 factors, which are many times outside of the
2 healthcare domain.

3 Healthy behaviors, which can be
4 addressed through counseling, but, again, a
5 lot of those are outside of the healthcare
6 setting.

7 And then the last one, effective
8 clinical preventative services, which tends to
9 be clearly much more healthcare-oriented.

10 But what we based our discussions
11 off of was thinking about what role factors
12 outside of the healthcare system play in
13 overall health. And when you look at work by
14 Francis Kendig with the County Health
15 Rankings, they did an assessment and showed
16 that healthcare is actually about 20 percent
17 of health. So if you're thinking about 80
18 percent of the determinants of health are
19 outside of the healthcare setting, you know,
20 it's something that's pretty much under-
21 represented in terms of measurement, because
22 much of measurement focuses on healthcare.

1 So that's something that that
2 group kept in mind when they were choosing
3 potential measures for the family. And then
4 you can see that the two measures that were
5 highlighted as initial indicators for
6 population health and the National Quality
7 Strategy focusing on depression and obesity.

8 So our Task Force used three broad
9 categories of determinants of health, health
10 improvement activities, and health outcomes to
11 guide their thinking. And then dove a little
12 deeper to come up with these specific topic
13 areas which were felt to be high-leverage
14 opportunities for improvement in population
15 health.

16 And it should be pretty self-
17 explanatory, but, again, a pretty diverse
18 range of topics and many of these focusing on
19 issues that are outside of the healthcare
20 setting.

21 So I'll spend a little bit of time
22 on this just because this was something that

1 the Task Force thought would be particularly
2 helpful in their work in terms of applying the
3 measures, which is what MAP is all about,
4 measure application.

5 So they thought it would be
6 helpful to develop use cases for how the
7 measures in the family might be applied. So
8 in the past, the families have been used
9 primarily for helping MAP to think about the
10 programs that CMS administers. And those are
11 all in the healthcare setting pretty much.

12 So the measures that were selected
13 based on this use case were things like
14 screening, controlling high blood pressure and
15 diabetes, immunizations, et cetera. So these
16 are all clearly things that apply to existing
17 CMS programs, and a number of those measures
18 were preliminarily selected.

19 So taking that one step further is
20 looking at Accountable Care Organizations.
21 Now, there is the Medicare Shared Savings
22 Program, which gets into some of these

1 concepts. But thinking even a little more
2 broadly, looking at system-level measures that
3 may apply across providers or healthcare
4 settings. And so thinking about an annual
5 dental visit that may not be something that
6 one provider knows about, but if you have a
7 comprehensive system and you're tracking
8 whether patients in that ACO are getting
9 services outside of just one provider, those
10 are some additional measures that may be
11 applied.

12 Community health needs assessment,
13 as many of you know, is now a requirement for
14 non-profit hospitals. And it takes a little
15 bit broader focus, not just on a healthcare
16 population, but a geographic population that
17 may be surrounding a hospital.

18 And so with this application you
19 may think about measures that are even
20 reaching more beyond the healthcare setting,
21 and so this example of looking at the number
22 of school days that children missed due to

1 illness.

2 And so those are the three use
3 cases we started with. During the meeting the
4 group actually wanted to take it a step
5 further and think about measures that would be
6 just very public health-focused. So this may
7 be for a health department or a social
8 services agency, and thinking about very
9 upstream determinants of health.

10 And so for this use case, there
11 was a few NQF endorsed measures, but a number
12 of the measures that were selected were
13 actually leading health indicators that are
14 part of Healthy People 2020, but the group
15 felt that it was important to include those
16 because these really, again, address very
17 upstream health determinants and also focus
18 more on geographic populations.

19 So it could be at a county level,
20 a state level, or even a national level in the
21 case of the Leading Health Indicators.

22 So that was the focus of the MAP

1 Population Health Task Force and I'll turn it
2 back to you.

3 DR. MCCLELLAN: Thanks. Any
4 clarifying questions for Allen before we turn
5 to measures and discuss some measures with
6 help from Mitra and Allen? Okay, great.

7 So, moving on, this table lists
8 some of the preliminary measures that you all
9 considered and favored for person- and family-
10 centered care and prevention measures, sort of
11 an aspect of the emphasis on community health,
12 population health, relevant to cost.

13 And if you look at the measures in
14 the lefthand column, those are all various
15 CAHPS measures, with one exception, the
16 advanced care plan metric. So we might put
17 together some of the CAHPS related
18 discussions. In fact, a lot of stuff in the
19 not selected but considered is also -- in
20 fact, all of it is CAHPS-related as well.

21 Obviously, there are some
22 potential measurement gaps and opportunities

1 beyond that as well, and I don't know if we
2 want to hold on this slide and save the more
3 extensive prevention discussion for -- oh,
4 right. You've got one prevention near the
5 bottom.

6 So the thing with the prevention
7 measures, as you just heard from Allen, there
8 are a lot that are obviously very relevant to
9 population health. The evidence on cost
10 impacts and affordability impacts is less
11 clear.

12 So once again, as in our other
13 discussions, not that these are unimportant
14 areas enough that they should be considered
15 along with affordability, but we're trying to
16 keep our focus here on the affordability
17 family and therefore the implications directly
18 on cost.

19 So maybe we could start with the
20 person- and family-centered care section, and
21 after we've gone through that maybe turn to
22 prevention and other population health

1 potential measurement areas.

2 And preliminary questions there
3 are pretty our usual ones: what do you think
4 of the preliminary measure, the preliminary
5 list of recommended measures, are there others
6 that should be included? And, you know, these
7 are areas that are both, obviously, very
8 important and still in further development.

9 So maybe some comments related to
10 next steps and future directions would be even
11 more important here. Kevin?

12 DR. LARSEN: I apologize, I have
13 to leave at two for a call, but as you saw
14 from the previous slides there were some other
15 domains besides experience, things like
16 outcomes, that have been identified as really
17 key for patient- and family-centered care.

18 And a couple of those I think
19 might be appropriate here. I'm thinking
20 specifically of depression in remission, you
21 measuring with the PHQ-9. There is some good
22 work through the Minnesota Diamond Project of

1 how that has been shown to correlate with more
2 days at work for people that have depression.

3 And so it actually has an
4 affordability, not necessarily in the
5 healthcare space, but it has an affordability
6 to the people that matter, that you're
7 actually at work more and your employer likes
8 that. And most people like that as well.

9 I think that that will likely
10 start to be demonstrated in other patient-
11 reported outcome measures. I think there is
12 some similar work in the asthma control
13 measure, which measures children's or adult's
14 control of their asthma. And we know that
15 children that have uncontrolled asthma miss
16 more school and adults that have uncontrolled
17 asthma also miss more work.

18 So I would put a plug in for
19 including here some PRO measures, those two
20 specifically.

21 DR. MCCLELLAN: Thanks. Peg?

22 DR. TERRY: I think on depression

1 there is some evidence out there that if
2 patients are depressed they don't engage as
3 much and so they don't engage and they don't
4 improve.

5 And so it can have an
6 affordability issue. But the other thing I
7 wanted to raise was, I'm sure people are
8 familiar, and in the area of home care we do
9 a lot with patient engagement and patient
10 activation. And so I'm sure people are
11 familiar with the PAM tool, you know, which is
12 not publicly available per se at this point.

13 But many of our members are using
14 it and they're finding that it's a good tool
15 for them to measure a patient's ability to
16 improve. So, again, how you tie that into
17 affordability though is another, you know, a
18 bit of a leap but --

19 DR. MCCLELLAN: I think here is
20 some evidence, and Kevin or others might want
21 to comment on this, too, about more engaged
22 patients using healthcare more effectively,

1 being more engaged in a care plan, which in
2 turn has, you know, significant costs as well
3 as out outcome --

4 DR. TERRY: Right. And I think
5 health literacy is another issue that, I don't
6 know that there's a good measure today on
7 health literacy, but it is part of engagement,
8 too. And how patients, you know, are able to
9 engage based on their literacy level, based
10 on, you know, again, how you get to them, how
11 quickly you get to them, how quickly they
12 grasp what they need to do. And so I think
13 some measure along that lines, I think, would
14 be helpful.

15 DR. MCCLELLAN: Thanks. David and
16 David?

17 DR. HOPKINS: So since CAHPS is
18 all over this chart, I can't help but comment
19 that CAHPS as we know it has, from what I
20 conceive, virtually no relevance to
21 affordability.

22 But isn't part of our job to

1 suggest to those who can help make things
2 change, and in this case I'm thinking of the
3 CAHPS team and ARHQ that commissions them, to
4 for goodness' sake start thinking about
5 affordability as an area that should be
6 explored to the CAHPS service.

7 DR. MCCLELLAN: So and that would
8 be just some of the direct questions about
9 impactive out-of-pocket-costs on your care or
10 things like that?

11 DR. HOPKINS: This is patient
12 experience, right? It fits right in there.

13 DR. MCCLELLAN: Okay. David?

14 DR. SEIDENWURM: I think that it
15 would be worth commenting just for a second
16 that there is some work that suggests that
17 patient satisfaction and patient engagement
18 result in higher cost and higher utilization.

19 So I'm not saying that that's
20 necessarily a bad thing, I mean, but it is
21 something in an affordability conversation
22 that has to be mentioned, I think.

1 DR. MCCLELLAN: Helen?

2 MS. HASKELL: Well, when you're
3 talking about prevention, I get very uneasy
4 when you start bringing things like
5 depression, which I assume is depression
6 screening, because I think that is a -- and
7 particularly when you're talking about people
8 who have had symptoms within the past 12
9 months as opposed to necessarily long term --
10 I think that is a ticket to over-treatment,
11 which is certainly not an improvement in
12 affordability and often not an improvement in
13 outcome. So when you measure things like --

14 DR. MCCLELLAN: Impact on work --

15 MS. HASKELL: Well, yes, the
16 depression going away, you're still not
17 measuring the effectiveness of the treatment.
18 I mean, there's also plenty of research out
19 there saying that antidepressants don't work,
20 but when you say treatment for depression
21 that's what people get.

22 So I think there's some real

1 issues around screening and particularly in
2 terms of cost, because I think the cost of
3 screening is high, unless it is something
4 that's really shown to be effective.

5 DR. MCCLELLAN: Yeah, and I think,
6 I mean, maybe that is a point for our broader
7 discussion. Kevin brought this up earlier,
8 too, you know, that kind of the better
9 evidence of more effective treatment of
10 depression or asthma or other conditions is
11 not short term healthcare cost savings, but,
12 you know, at least offsetting savings in other
13 areas as well as longer term better outcomes,
14 and maybe avoided complications in the future.
15 And that's at least a point that we should
16 probably note in our report if we do move
17 forward with some of these recommendations.

18 DR. LARSEN: Yeah, so the thing I
19 was actually referencing is are these patient-
20 reported outcomes, which are standardized
21 scales that measure a baseline, and through
22 time are you getting better?

1 And the groups that focus on that
2 use many tools, including antidepressants, but
3 also therapy, any number of tools to help
4 achieve a better outcome. And they know they
5 have a better outcome because they are using
6 a standardized tool of symptoms, essentially,
7 of depression.

8 So it's people that have the
9 outcome of less depression symptoms are the
10 people that have less missed days of work.
11 And it's the same with asthma. It's not
12 measuring did you take the medicines, it's a
13 standardized assessment of is your asthma
14 controlled.

15 And that is what leads to less ER
16 visits, that's what leads to less missed days
17 of school, and less missed days of work. And
18 so that's the sort of promise of the patient-
19 reported outcomes.

20 MS. HASKELL: No, I think patient-
21 reported outcomes and screening are very
22 different. And my concern is the screening,

1 getting people into treatment who might not
2 need treatment, who then might well report a
3 good outcome with or without treatment.

4 I just think there are real issues
5 there because these treatments are not without
6 harms and they're certainly not without cost.

7 DR. MCCLELLAN: Koryn?

8 MS. RUBIN: So in regard to HCAHPS
9 and the affordability, I mean, there's a
10 possibility there's some questions in there
11 that may actually be driving up costs,
12 particularly in regards to the pain management
13 questions. And that's something I've been
14 regularly recently hearing from physicians.

15 Their concern and their issue with
16 being judged on pain management given, you
17 know, that's a subjective thing, and based on
18 whatever the patient is in there for, their
19 tolerance for pain is different. And with the
20 opioid problem that we have in this country,
21 there's a real concern from physicians that
22 their care is being judged based on how the

1 patient feels with how their pain was
2 controlled in the hospital.

3 DR. MCCLELLAN: Thanks. Wei?

4 DR. YING: One thing about
5 patient-reported outcomes, the issue we run
6 into is PHQ-9, when physicians use it they
7 actually come up, I think it's the
8 standardized treatment suggestion. So if it's
9 between zero to five, do nothing; five to ten,
10 do this; ten to 15, do this.

11 So there is a standard treatment
12 plan per se. Of course every person is
13 different, so they can vary a little bit, but
14 there is a standard structure there. But when
15 we try to do the hip and knee, we run into
16 problem because the physicians see the score
17 but they don't know what to do with it.

18 So that will lead to sometimes
19 unnecessary use or even inappropriate use. So
20 use the prompt, instead of at the very end and
21 just retroactively say, well, yes, it
22 happened, to make it become part of the

1 treatment to control the cost to make the care
2 better. The developer, or I don't know who,
3 needs to come up with something to pair with
4 the tool itself in terms of the standardized
5 treatment plan, or at least a suggestion if
6 it's not a standardized --

7 DR. MCCLELLAN: Pair it with a
8 standardized treatment plan which would also
9 give more confidence about the cost impacts of
10 this. Nancy and Aparna?

11 MS. FOSTER: So I don't have any
12 great passion around the 0326 Advanced Care
13 Plan, which just records whether a patient age
14 65 and older has one, but it seems lackluster
15 absent the measure that says, was it followed,
16 was it adhered to when they came to end of
17 life or whatever advanced care planning
18 they've done.

19 And having recently gone through a
20 family experience with this, I can tell you
21 there are all sorts of state laws that get in
22 the way here. So I'm just nervous about what

1 that particular measure would tell us vis-a-
2 vis affordability, let alone anything else.

3 DR. MCCLELLAN: Aparna?

4 MS. HIGGINS: So I just wanted to
5 echo David's comments about I'm not seeing the
6 link between these CAHPS surveys and
7 affordability, so, I mean, as they are.

8 I know it's a long survey so I,
9 you know -- and I think some of the types of
10 measures that, you know, Kevin was describing
11 to me seemed much more relevant to what we're
12 trying to do here.

13 DR. MCCLELLAN: So patient
14 reported outcomes about control of the chronic
15 conditions?

16 MS. HIGGINS: Asthma, yeah.

17 DR. MCCLELLAN: Yes. Okay.

18 MS. HIGGINS: Depression.

19 DR. MCCLELLAN: Yes.

20 DR. SEIDENWURM: Is it appropriate
21 to have those patient-reported measures as a
22 control that maybe some of the other

1 affordability measures aren't reducing the
2 quality of the patient experience? Maybe
3 that's why we have those --

4 DR. MCCLELLAN: Well, that's
5 balancing measures and we're going to talk
6 about that in the next session.

7 DR. SEIDENWURM: Right. Okay.

8 DR. MCCLELLAN: And I think that
9 is -- you know, if it's not affordability that
10 doesn't mean it shouldn't be considered with
11 affordability, but it probably does mean it's
12 not part of this family. Yeah, Gerri?

13 DR. LAMB: Yeah, along with what
14 everybody is saying, I'm sitting here
15 wondering, so, what is it within person and
16 family that really does drive cost? And I
17 think, Mark, you had mentioned some of the
18 beginning work in engagement suggests, like
19 Judith Hibbard's work, suggests that it does
20 have a cost impact, but that's really very
21 early on.

22 DR. MCCLELLAN: Yeah, that's

1 right.

2 DR. LAMB: And so, you know, I
3 guess the other one that I was wondering --

4 DR. MCCLELLAN: Yeah, we're going
5 to go ahead and put up the gap slide which
6 highlights these --

7 DR. LAMB: Go back for a sec,
8 though, the 1902 -- what is the literacy one?
9 Is that getting anywhere near, you know,
10 something that might impact the ability to
11 make decisions about health services or use
12 them? What is that one actually measuring?

13 DR. MCCLELLAN: While we're
14 looking at that, Kevin, any comments about
15 evidence on literacy and impact on cost?

16 DR. LARSEN: So, I don't know
17 about interventions. When I was doing
18 research we were in the space of looking at
19 could health literacy interventions actually
20 decrease cost.

21 There's a really high correlation
22 between low literacy and increased costs, but

1 the literature on whether or not we can
2 intervene in effective ways and lower the cost
3 is far less robust.

4 There is some work done in certain
5 places, like diabetes care, that I think has
6 started to show it. The work has morphed is
7 into care coordination work, frankly, because
8 it turns out not to be really about the
9 printed materials, but more about what's the
10 experience of care and how is it as
11 straightforward to get the care you need
12 versus how much you need to have high literacy
13 to work your way through a really complex
14 system with lots of barriers and
15 disconnectedness.

16 So there, yeah, I think the data
17 to date is low on interventions.

18 MR. SAUNDERS: And to jump in on
19 1902, so 1902 is a composite that's built out
20 of the CG-CAHPS survey which includes
21 basically questions about communications with
22 doctor, provider, disease self-management,

1 communication about meds, communications about
2 test results, and communication about forms.

3 So it doesn't necessarily get to I
4 think your question exactly. It's trying to
5 say did the provider, you know, use the
6 appropriate types of communication which
7 hopefully would be useful for improving health
8 literacy?

9 DR. LAMB: Along those lines, the
10 domains that are being looked at for care
11 coordination now have literacy, but it's in
12 the structural variable column in terms of
13 impacting, so it's pretty far downstream from
14 what we're talking about here.

15 DR. MCCLELLAN: Yeah. Aparna?

16 MS. HIGGINS: So I'm sort of
17 pondering a little bit David's earlier
18 suggestion about adding questions to CAHPS,
19 and I'm wondering if maybe we should think
20 about some more sort of global measures like,
21 you know, what percent of your income you
22 spend on healthcare, for example, would be

1 sort of a good way to look at, you know, the
2 affordability.

3 In the context of a survey, you
4 know, or, for example, I don't know if, you
5 know, data sets like MEPS would allow us to
6 get at that. You know it might be other
7 sources beyond surveys to try to get at that
8 particular issue about, you know, share of
9 income spent.

10 You look at share of income spent
11 on food and housing and so forth, so
12 healthcare would be, you know, one such --

13 DR. MCCLELLAN: There are a lot of
14 survey questions about affordability and
15 whether cost impacted care.

16 MS. HIGGINS: Right. And the
17 other issue I think tied into that is the
18 opportunity cost, so, you know, what else --
19 it's kind of like the same crowding out effect
20 that we talk about of government spending.

21 At the individual level, like,
22 what did you forego because you had to spend,

1 you know, twice as much on healthcare, for
2 example.

3 DR. MCCLELLAN: Kevin?

4 DR. LARSEN: Yeah, some additional
5 thought about caregivers, I think, is key here
6 because we know that for many of these
7 patients and conditions a huge financial
8 burden is born by their caregiver.

9 So if you think of a parent of a
10 child who's chronically ill, that's a pretty
11 straightforward one, but what's less
12 straightforward is the child of a parent who
13 is cognitively declining but still living at
14 home and trying to navigate a really complex
15 set of healthcare systems and services. And
16 the amount of spend on behalf of that child of
17 the elderly person could be quite high.

18 It's an important component as we
19 think about person- and family-centered care
20 and it's part of the reason we talk about
21 here. One of the drivers for things like
22 nursing home admissions, I think most of you

1 know this, one of the common reasons you enter
2 into a long term care is incontinence and
3 that's because it's so much a challenge to
4 manage at home and it costs to manage at home.

5 So I don't think we have anything
6 there yet and it's not going to be an easy
7 one, but I think it's pretty impactful.

8 DR. MCCLELLAN: Thanks. Don?

9 MR. MAY: You know, I don't have a
10 measure here, but I think that as we talk
11 about getting information from patients we're
12 seeing through some of our companies that,
13 device companies are trying to use wireless
14 communications, personal handheld devices to
15 start to collect information and finding a way
16 to add that to the information that we are
17 collecting from people is I think going to be
18 very important.

19 We're already seeing in cardiac
20 care where people with COPD can go home and
21 there's a monitor that's wirelessly sticking
22 to some device, I think it's an iPhone or some

1 kind of app in the home, the thing gets
2 transferred to the physician.

3 You know I think historically
4 we've seen very little growth in that from a
5 real perspective, I mean where technology
6 could really improve collection of information
7 from the patient because, to be honest, as
8 we've talked to device companies, there's not
9 a lot of, there was no way of incentivizing
10 that.

11 But as hospitals are trying to
12 prevent readmissions and that's where the
13 cardiac care project started, they were trying
14 to prevent readmissions, and all of a sudden
15 there was a real interest in having this
16 wireless technology communicate information.

17 And I think, you know, that's an
18 example that maybe gets more care
19 coordination, but I think, you know, whether
20 it's I have a Fitbit and I can tell you on my
21 phone how many steps I make and then that goes
22 up to the web and tells my friends, you know,

1 I think there's opportunities here to be
2 thinking creatively about how to get
3 information from patients in a different way
4 other than just a survey.

5 DR. MCCLELLAN: All right, thanks.
6 Peg?

7 DR. TERRY: So as Aparna, is that
8 how you say it --

9 MS. HIGGINS: Yes.

10 DR. TERRY: -- was speaking and
11 she said "well" at the end maybe it's what,
12 you know, how you make decisions about getting
13 one thing as opposed to another and I know
14 there's been a lot of discussion that patients
15 don't get their meds filled because they have
16 to buy food or whatever it is, there's a lot
17 of, you know, discussion around that.

18 But I do think that's an important
19 way to get at the issue for some people and I
20 don't know what survey it could be in, but I
21 think there is a way to kind of look at, you
22 know, you make decisions about what you can

1 afford and some things you can't afford if
2 you're having a heart attack possibly.

3 But there are other things that
4 you make decisions on affording and so the
5 question, you know, how do you embed something
6 that says well, have you decided not to do,
7 and meds are a good one, but have you decided
8 not to do this because, you know, it's
9 something you decided you needed to spend
10 money on something else or something like
11 that.

12 So I don't know if it could be in
13 an HCAHPS or what, but, or another CAHP, you
14 know, one of the CAHPS or somewhere else, but
15 I think making decisions about the
16 affordability is a really concrete way maybe
17 of getting at it, to get some of the --

18 DR. MCCLELLAN: Thanks. Jim and
19 Helen?

20 DR. DUNFORD: Just picking up on
21 Don's point. I was impressed by the Camden
22 Collaboratives success in bending the cost

1 curve of their superuse and population because
2 they basically partnered with the faith-based
3 community and they worked with the Baptist
4 churches and it was really those care
5 providers that actually were the glue that
6 kind of stabilized the situation.

7 And I think using those kind of
8 community-based resources to be able to copy
9 the whisper that begins to describe when
10 there's a problem brewing and then
11 communicating that information back to the
12 primary care physician team is really an
13 untapped resource.

14 Kevin and I were just talking
15 about this awhile ago, this sort of ability to
16 train people to use simple social techniques
17 and wireless services to be able to start to
18 push information to caregivers is actually
19 going to be really a powerful tool.

20 And so the gap is basically
21 identifying, you know, what are the valuable
22 points that we need to know, you know. I mean

1 there may be a car, but there may not be a car
2 today to get to the doctor's office, that's a
3 huge differential.

4 And there may be, you know, no air
5 in the tires or ten other things that can
6 cause transportation to be the issue just this
7 week and maybe next week it isn't going to be
8 the issue.

9 So something has to be fairly
10 dynamic, particularly for hyper-vulnerable
11 people.

12 DR. MCCLELLAN: And that is a
13 connection between, especially for high, as
14 you said high risk or hyper-vulnerable
15 individuals, these non-medical support
16 connections seem to be very important as the
17 rolling evidence on that from Camden and lots
18 of other places including, Kevin, your old
19 home.

20 I'm not clear on what a measure of
21 that would be that we could recommend though.
22 I mean I think it's one thing to talk about

1 the directionality, but --

2 DR. LARSEN: If I could speak up?
3 There are a couple groups working on this,
4 kind of in a backdoor way. So there's
5 actually a vendor, an interesting kind of not-
6 for-profit vendor that goes into clinics and
7 helps patients fill out a survey of I need
8 food, I need help with forms, I need help with
9 transportation, and then they get college
10 volunteers that they've trained to connect
11 these patients to those services.

12 Well that survey then becomes a
13 measurement, because now it's quite
14 standardized, it's structured, it's in
15 actually a number of different communities
16 across the country and they've done a lot of
17 work with the informatics on structuring their
18 survey and they can actually show to practices
19 the improvement they make on those sort of
20 survey scores and the linkages to community
21 services and then, and they're now working on
22 how that's decreasing healthcare costs when

1 people have had these other kind of service
2 needs met.

3 DR. MCCLELLAN: So that's a health
4 leads and --

5 DR. LARSEN: It's health leads,
6 exactly.

7 DR. MCCLELLAN: -- you know, some
8 other groups that --

9 DR. LARSEN: There's some other
10 groups that did it.

11 DR. MCCLELLAN: Yes.

12 DR. LARSEN: It's that you could
13 imagine a model where you take this sort of
14 health leads idea and then build it into
15 survey.

16 I know that groups like United
17 Healthcare in all of their care coordinations,
18 we have been thinking along the same way.

19 What are the key questions that we
20 ask that tell us, for example, who needs
21 additional home services, who needs additional
22 care coordination, so they can identify those

1 people, get targeted services like Camden
2 does, and know that they've decreased costs.

3 DR. MCCLELLAN: Yes, thanks.
4 Helen?

5 MS. HASKELL: Well much less
6 global really, but going back here, I think
7 shared decision making and informed choice are
8 really critical to reducing costs, so getting
9 that really right up at the beginning so that
10 people know what their options are.

11 And the other end of that is
12 patient reporting after adverse events and
13 patient involvement, you know, in
14 investigation of adverse events so that you
15 get the information to prevent them fed back
16 into the system.

17 And then, you know, along the
18 lines of what Kevin and Jim were just talking
19 about, behavioral health, the flip side of
20 what I was saying earlier about depression is
21 that we, is the lack of resources for people
22 with severe behavioral health issues and I

1 wonder if there is not a way to survey for
2 that, you know, or do some sort of survey that
3 would, a measure that would push communities
4 to put programs like this into place.

5 DR. MCCLELLAN: Thanks. Next I
6 have Wei.

7 DR. YING: I'm also a member of
8 the population group so I can actually, I'm
9 actually looking at a measure we voted on.
10 There's one measure, it's not getting at the
11 productivity per se, but basically the measure
12 is the number of school days children miss due
13 to illness.

14 So that's the only one that's from
15 children, you get to the parents a little bit,
16 so it's some, at the surface, just to touch on
17 the concept that we're talking about, indirect
18 cost, that's one thing I wanted to point out.

19 The other thing is during that
20 group's discussion obesity and smoking,
21 everyone recognized from the population point
22 of view that those are the leading factors for

1 the downstream costs later on.

2 I'm not sure whether for this work
3 group do we want to add anything, since we
4 didn't touch anything on that? I think
5 smoking cessation is part of the CAHPS survey
6 or some survey that health plan actually does
7 to their, basically requires to the --

8 (Simultaneous speaking.)

9 DR. MCCLELLAN: Yes, there's some
10 direct measures on that.

11 DR. YING: Yes.

12 DR. MCCLELLAN: I think the cost
13 impact, again, is a bit less clear. I mean
14 those conditions are associated with higher
15 costs, particularly obesity.

16 DR. YING: Right.

17 DR. MCCLELLAN: And so I think
18 maybe, you know, smoking and obesity in
19 particular are on the list of measurement gap
20 areas. So I'm actually guessing maybe like a
21 smoking cessation measure could be --

22 MR. DYER: Smoking and for the

1 BMI. I think for the population health, for
2 the population group they have those in
3 specific measures targeting the obesity and
4 the smoking.

5 DR. MCCLELLAN: Yes.

6 DR. YING: Maybe we can pick, if
7 we want we can pick one or two from there.

8 DR. MCCLELLAN: Okay.

9 DR. YING: Okay.

10 DR. MCCLELLAN: Koryn?

11 MS. RUBIN: Yes. So in regards to
12 disease management is there maybe some kind of
13 measures and I know you guys briefly discussed
14 about cost shifting, but when you have
15 possibly, you know, a medication that's
16 prescription and then it's moved to over-the-
17 counter, so the patient originally had a \$10
18 co-pay and now they have to pay the full price
19 of \$30, \$40, and now that's fully out-of-
20 pocket where before there was some share in
21 the cost.

22 And then in regards to

1 prescription limits where often the pharmacy
2 benefit managers place limits, but like we
3 know with eye drops in an elderly population
4 they often exceed the limits within the month.

5 So if they need more prescription
6 they have to pay the full price of the
7 medication so that leads to, you know, the
8 creative ways of managing their disease and
9 often exasperating the disease where they now
10 then will need, you know, some form of surgery
11 where it could've easily been managed by
12 medication if they had access to the right
13 amount of medication.

14 DR. MCCLELLAN: Thanks. Jim?

15 DR. DUNFORD: Just a brief comment
16 that some of the gaps that are identified in
17 this family actually have been picked up by
18 the Duals because a lot of patient and family
19 centered care and prevention really is Duals,
20 that's really what that work group, or task
21 force, is really all about.

22 So, for example, we have

1 initiatives in smoking and alcohol and drug
2 abuse and immunization, a number of these
3 things. I wouldn't list them all, but just
4 there's a lot of cross-pollination here.

5 DR. MCCLELLAN: Okay. Kevin?

6 DR. LARSEN: Yes. As I look at
7 this area I think there is some potentially an
8 NQF endorsed measure here we could put in that
9 screening and brief intervention for alcohol
10 use that does have good evidence from
11 Wisconsin about decreased costs when you get
12 people into alcohol treatment.

13 Actually it's about decreasing
14 peoples use of alcohol before they end up with
15 a diagnosis of alcoholism. And so, again, the
16 costs are mostly societal costs and work
17 related costs as opposed to being what we
18 think of as healthcare costs.

19 But there are some healthcare
20 costs decreases that have been shown with that
21 particular measure.

22 DR. MCCLELLAN: Okay. So just in

1 a sense of I, let me see if I can try to get
2 a sense of where we are, so we go back to the
3 measures that we started with.

4 I didn't really hear a clear case
5 for much in terms of the current CAHPS
6 measures of a clearer link to impact on costs
7 and to keep this report contained and
8 enforceful, without that it's awfully hard to
9 provide a recommendation.

10 Sticking with patient reports
11 though, there are some very promising measures
12 and some promising directions for further work
13 including patient reported outcomes like
14 control of disease, you mentioned asthma,
15 diabetes, severe behavioral health issues, and
16 patient reports about occurrence of adverse
17 events.

18 I think those are, we talked about
19 earlier, not well captured and maybe measures
20 that get at secondary costs like school days
21 missed, but more clearly a recommendation that
22 from both surveys and CAHPS it should be

1 possible to get direct questions from patients
2 and consumers about the affordability of their
3 care.

4 So some of that's available now in
5 surveys like MEPS, you know, percentage of
6 income going to healthcare costs and people
7 who are having trade-offs between using
8 medical and other services, what other
9 consumption they are foregoing.

10 Measures along those lines could
11 potentially be incorporated in CAHPS.

12 Similarly, while shared decision making is a
13 goal there is not a lot of enthusiasm for the
14 advanced care plan measure on the list either
15 since it's just kind of, you know, does it
16 exist and as Gerri was saying not much
17 evidence that it actually does have an impact
18 on cost.

19 So sticking with that standard I
20 think we wouldn't endorse it explicitly, but
21 measures of shared decision making, measures
22 of whether a patient care plan was actually

1 followed in delivering care to a patient would
2 potentially be relevant.

3 And with respect to health
4 literacy, clearly associated with differences
5 in costs, however, the evidence, at least as
6 we've summarized it here, on how to reduce
7 costs for particularly less literate, health
8 literate patients, it really goes back to the
9 coordination of care measures and having a
10 less complex system to navigate.

11 We've covered a lot of those
12 measures already in the care coordination
13 section. Let me pause there, and I'm going to
14 get to the prevention measures in a second,
15 does that sound about right, yes?

16 DR. TERRY: Patient activation.

17 DR. MCCLELLAN: Yes, patient
18 activation, too. I think it's a promising
19 direction, but, again, not yet evidenced that
20 it has an impact on cost.

21 So, you know, I think to the
22 extent that this report can particularly flesh

1 out how these activities like patient
2 engagement or, you know, better coordinated
3 care, or impacts on health literacy could
4 actually affect cost, that would be very
5 helpful in hopefully guiding the further
6 development of those measures. Yes, Nancy?

7 MS. FOSTER: So, Mark, I'm not
8 sure I heard it in your summary, but I think
9 there was some general support around the
10 notion that while CAHPS is not a particularly
11 helpful tool right now --

12 DR. MCCLELLAN: Right now, but it
13 could be.

14 MS. FOSTER: -- it could be.

15 DR. MCCLELLAN: Absolutely. I
16 think that may be the lead point is that it,
17 you know, we do have examples in well done
18 surveys of questions about affordability to,
19 you know, individuals and patients.

20 So for now we can potentially use
21 measures from those surveys about
22 affordability that would be valuable, but the

1 aim should be incorporating that more directly
2 in future versions of CAHPS.

3 With respect to prevention, for
4 many types of preventative care, very good to
5 do, important from a public health and quality
6 of care standpoint, but less clear evidence on
7 impacts on costs.

8 You all mentioned some potential
9 exceptions though that probably are worth
10 putting in a report. One is BMI, since
11 obesity is associated with higher healthcare
12 costs in the short term and we do have a good
13 BMI measure.

14 A second is smoking cessation, the
15 evidence there on healthcare costs impacts is
16 less direct, but once again there are measures
17 and at least some reason, and maybe we can
18 check on this in our follow up, some reason to
19 think that would lead to lower cost.

20 We also had an example of alcohol,
21 drug abuse screening, and a brief treatment
22 measure where we think there's some

1 connection, too.

2 I don't know if we can go forward
3 to that slide, if there was anything else on
4 the list where, you know, it does seem like
5 there's this plausible and direct tie to cost
6 we should probably, you know, while you're
7 thinking about that I did leave out there are
8 the health leads and community resource
9 measures I think are worth mentioning, too.

10 There is, as Kevin mentioned, a
11 good deal of validation, at least for high
12 risk patients that doing assessments and
13 addressing non-medical service needs like
14 housing, food, and the like, can have a
15 significant impact on healthcare costs, so I
16 think that's worth including as well. Nancy?

17 MS. FOSTER: So behavioral health
18 obviously an important area, I'm wondering if
19 we can get started, Kevin, by looking at
20 depression as a comorbid condition when a
21 patient is in treatment for something else.

22 We know it occurs. We know it can

1 exacerbate costs, and at least if we were
2 preventative --

3 DR. MCCLELLAN: But is there a
4 measure of like, so it sounds like what we're
5 getting at is treatment of depression as a
6 comorbid condition --

7 MS. FOSTER: Yes. And I don't
8 think there's a measure yet, but --

9 DR. MCCLELLAN: -- and is there
10 anything we have on that? I don't think so.

11 DR. LARSEN: I'm right now --

12 DR. MCCLELLAN: Yes?

13 DR. LARSEN: It turns out NQF just
14 endorsed 20-odd behavioral health measures in
15 March and so I'm looking through the list
16 right now and I don't see anything about a
17 comorbid condition.

18 There's a whole suite though of
19 depression and tobacco and alcohol measures
20 here.

21 DR. MCCLELLAN: Good. Ron?

22 DR. WALTERS: I apologize again,

1 I'm a little bit of a visionary and I think we
2 have a golden opportunity in front of us. In
3 other NQF reports there's this very nice
4 diagram that goes from the left hand side,
5 population health, through prevention and
6 screening, through an episode of care, through
7 the post acute care, and you can carry it, you
8 can break that down to as many levels as you
9 want to.

10 And it shows, it's usually disease
11 focused, so there's like, the one that's in
12 the publication is cardiovascular disease, and
13 it walks you through what kind of measures are
14 available at the population level, what kind
15 of measures might be available at the
16 prevention and screening level, what kind of
17 measures might be available that we end up
18 talking about, mostly treatment related and
19 complications of care and so on, et cetera, et
20 cetera.

21 I think there's a wonderful
22 opportunity, granted it's not even going to be

1 as built out as much of that, as that one is
2 to link the results of this task force,
3 affordability to that.

4 Because the concept that we're
5 getting into now, that we all know is true,
6 but there's a tremendous gap in knowledge, is
7 that for some things it's a heck of a lot
8 cheaper to avoid a problem than to treat it
9 once it happens.

10 And the sorts of diagrams that
11 exist there for conditions are a natural
12 framework and we've kind of walked our way
13 these last two days, we're getting to the left
14 hand side now finally.

15 Now the trick is, of course, that
16 in population health you don't know what
17 you're talking about yet because you don't
18 have a condition, you're just at risk for
19 different things.

20 And so there is a little bit of a
21 graphical problem there in portraying that,
22 but some of the concepts that we've talked

1 about that are proven measures at a population
2 health level could fit into that sort of
3 graphical display and there could be a couple
4 of examples that tie it into a specific area
5 like, whatever, diabetes or cardiovascular
6 disease, or something, to show conceptually
7 the mode of thinking that we're going to.

8 DR. MCCLELLAN: Yes.

9 DR. WALTERS: The other thing that
10 that might --

11 DR. MCCLELLAN: Would that work
12 for obesity or, yes, that would?

13 DR. WALTERS: It'd work for, it
14 probably would --

15 DR. MCCLELLAN: No.

16 DR. WALTERS: -- for a lot of
17 things.

18 DR. MCCLELLAN: No.

19 DR. WALTERS: But the other thing
20 it displays and the reason it's so important
21 is all this care coordination we're talking
22 about.

1 I mean that comes out just easily
2 when you start looking at the hand-offs that
3 have to occur and how the measures either
4 support those hand-offs or, as we've spent a
5 great deal of time talking about, sometimes
6 don't support them because they don't exist
7 when gaps exist.

8 So it's really more of a, just to
9 put some thought, and, again, like I said I'm
10 kind of a visual type person, into a one
11 figure schema that shows kind of the thinking
12 process that we went through in a lot of areas
13 over the last couple days.

14 But this is the golden opportunity
15 to do that and we aren't going to get a better
16 one.

17 DR. LARSEN: One example for that
18 might be Med Management. Because if you think
19 about a key opportunity for saving money in
20 adverse events and overuse and side effects,
21 et cetera, is having a much cleaner Med
22 Management and we're all actors in the Med

1 Management sort of framework.

2 MR. NELSON: Comment from Gene.

3 DR. MCCLELLAN: Yes, go ahead,
4 Gene.

5 MR. NELSON: I'm thinking about
6 what was said about the diagram with the at
7 risk population on the left and once again the
8 potential value of a rolled up measure of
9 health risk, just if there's real value of a
10 rolled up measure of harm.

11 And with respect to rolled up
12 measures this is something that a group has
13 been working on for a few years now for
14 avoidable risk of death.

15 Chris Murray's group at the
16 University of Washington that coordinates the
17 global burden of illness work and a group from
18 Dartmouth and more recently a group from
19 Framingham have been working on validating for
20 adults avoidable risk of death.

21 And the validation results are
22 very positive. So either the Framingham Index

1 is one kind of risk index that's very helpful
2 at both the population and individual level.

3 For example, when I see my
4 internist periodically he will actually take
5 out the Framingham Index values and coach me
6 about what I can do to reduce my risk.

7 So if you take the Framingham Risk
8 Index and then enhance it with, based on the
9 rest of the data, the meta-analyses, for
10 health behaviors there's a potential for a
11 Framingham Index plus that gets at other
12 behavioral variables that could be very
13 helpful in the future.

14 DR. MCCLELLAN: Thanks. Yes, go
15 ahead.

16 MR. NELSON: The overall avoidable
17 risk of death statistics for predication are
18 as good as the Framingham is for
19 cardiovascular death and the Framingham group
20 has validated the approach in their cohort,
21 vis a vis a National cohort, so it's very
22 promising for the future.

1 DR. MCCLELLAN: I've seen the
2 validation of that measure and it is very
3 promising. I guess in terms of this group I
4 do want to try to keep the focus on yes, we've
5 actually shown an impact on cost and, Ron,
6 Gene, you guys are right, these are
7 unquestionably good predictors of things that
8 can, of foundations for preventing costly
9 complications.

10 Unfortunately, it's still another
11 step beyond that to be able to conclude that
12 it's actually reducing healthcare costs as
13 opposed to just, you know, increasing value
14 from people living longer and better and there
15 is certainly some components of these metrics
16 like BMI that do have correlations with, you
17 know, reducing healthcare costs in the short
18 term.

19 So I think the framework sounds
20 good. I think we probably want to call for,
21 you know, sort of clearer links to cost saving
22 as a criterion for including it in the

1 affordability group. Nancy?

2 MR. NELSON: Right. You're --

3 DR. MCCLELLAN: Sorry, go head,
4 Gene.

5 MR. NELSON: I think I agree with
6 what you just said, Mark. From an economic
7 point of view the value of premature death or
8 the cost associated with premature death to
9 the community are --

10 DR. MCCLELLAN: Yes. It is
11 tremendous, yes.

12 MR. NELSON: -- unknown and
13 untabulated. And so in that sense there are,
14 to the communities, to the employers, et
15 cetera --

16 DR. MCCLELLAN: Right.

17 MR. NELSON: -- there are
18 potential, very, very strong cost savings
19 potential.

20 DR. MCCLELLAN: Right. And that
21 is something, the secondary benefits are
22 something that we do need to consider in this

1 section, too, thanks, or at least mention in
2 the report. Nancy?

3 MS. FOSTER: Sorry, one other
4 thought occurs to me, which Jim would be more
5 able to expound upon if it's necessary, but
6 did we make a mistake in leaving prevention of
7 trauma off of here?

8 MALE PARTICIPANT: Yes.

9 MS. FOSTER: I'm thinking of car
10 seats, bicycle helmets, those sorts of things.

11 DR. MCCLELLAN: And that gets back
12 to your point about injury, too, yes.

13 DR. DUNFORD: Yes, and again that
14 was, these data that were just presented by
15 CDC this week on the five leading causes of
16 death and what percentage of them were
17 calculated to be preventable. And so
18 probably, I don't know what, somewhere around
19 30 percent at least of trauma deaths are
20 preventable.

21 And they list for all of five
22 leading causes of death. Cardiovascular and

1 lung disease and the other things that we're
2 talking about. Cancer.

3 DR. MCCLELLAN: Okay. Okay, if
4 there's a metric there. Koryn?

5 MS. RUBIN: No, I'm fine.

6 DR. MCCLELLAN: Okay. Do you have
7 what you need?

8 MR. SAUNDERS: I think we have
9 what we need.

10 DR. MCCLELLAN: Okay, great. This
11 was a wide-ranging discussion and I want to
12 thank Allen and, well I guess I can't thank me
13 for in-person, but I thank you guys for taking
14 the time to help us through this and hopefully
15 the discussion will also help connect further
16 with the work that you're, the important work
17 that you're doing.

18 Right, so we are onto our next
19 and, this is the last section, right?

20 DR. DUNFORD: It is.

21 DR. MCCLELLAN: Well we got to
22 wrap up, okay.

1 DR. DUNFORD: Yes.

2 DR. MCCLELLAN: Our last
3 substance, I'm getting a little sad about
4 that.

5 So this is an update on
6 affordability projects across the NQF and
7 their alignment with NQF's linking cost and
8 quality measure, linking cost and quality with
9 our group here.

10 So we've talked about, repeatedly,
11 during this time the importance of not looking
12 at affordability measures by themselves and
13 the importance of us not viewing our job as
14 coming up with measures for everything that
15 you'd want to consider in conjunction with
16 affordability.

17 But now is the time to think and
18 talk more explicitly about how we do that
19 together. And any contributions or thoughts
20 that this groups has on the overall strategy.

21 So I think we're going to hear
22 from Rob and Lindsey. Welcome. Oh sorry,

1 Chris.

2 MS. MORESELL: Ashley. I didn't -

3 -

4 DR. MCCLELLAN: Ashley.

5 MS. MORESELL: I'm a fill in for
6 Lindsey --

7 DR. MCCLELLAN: Okay.

8 MS. MORESELL: -- so.

9 DR. MCCLELLAN: Okay. Ashley,
10 very nice to meet you and we'll hear from you
11 all about some of this other work that's
12 ongoing and use that as a basis for our
13 further discussion.

14 MR. SAUNDERS: Great. And so my
15 colleague Ashley and I will sort of tag team
16 this.

17 There's a portfolio projects
18 ongoing at NQF really around this question of
19 cost, resource use, affordability. This is in
20 fact, there's five and this is one of those.
21 And they sort of attack the question from
22 different angles.

1 And so I thought, Ashley will sort
2 of head up some of the ones really thinking
3 about cost of resource use measurements, there
4 are new measures for that. How we're thinking
5 about linking cost and quality.

6 We'll also sort of talk about
7 looking at affordability from the patient's
8 perspective, which is another project we have
9 ongoing.

10 And then there's very technical
11 project thinking about how to construct
12 episodes and episode groupers and we may just
13 wave at that but just to note that there is a
14 project there that has some impact on our
15 technical ability to measure cost.

16 So why don't we just switch to
17 here and I'll ask Ashley's indulgence to start
18 us off maybe on the high level thoughts on our
19 cost and resource use measurement and --

20 MS. MORESELL: Okay.

21 MR. SAUNDERS: -- maybe some
22 initial reactions to our meeting last week

1 about linking --

2 MS. MORESELL: Sure.

3 MR. SAUNDERS: -- cost and
4 quality.

5 MS. MORESELL: So should I start
6 with the --

7 MR. SAUNDERS: Oh, you should feel
8 free to start wherever you like --

9 MS. MORESELL: Oh.

10 MR. SAUNDERS: -- with high level
11 thoughts and --

12 MS. MORESELL: Okay.

13 MR. SAUNDERS: -- we will go form
14 there.

15 MS. MORESELL: So some of you
16 actually in this room have been apart of our
17 ongoing cost work. But we started, I guess,
18 about three or four years ago in this cost
19 measurement area.

20 Obviously NQF was kind of founded
21 on quality measurement and performance
22 improvement from the quality perspective and

1 we kind of moved into this cost space so it's
2 reactively new for us. But we have been
3 learning a lot.

4 And our first kind of endeavor
5 into the cost measurement space was through
6 cost measure endorsement project. We're now
7 on our third or fourth project now and have a
8 small portfolio of cost measures that are
9 endorsed.

10 We're still learning a lot there
11 and there's lots of challenges as you might
12 think, as you might guess, about evaluating
13 cost measures for various purposes.
14 Particularly when it comes to payment and
15 things like that.

16 And since then we have expanded
17 our work to include efforts around trying to
18 understand how to link cost and quality
19 measures. Our first, I guess, consensus
20 development project around endorsing cost
21 measures, our committee was really
22 uncomfortable with just focusing just on cost

1 measures.

2 We had always really kind of
3 having started out obviously in the quality
4 arena wanting to think about cost and quality
5 together and how those two signals give us
6 information about efficiency and value. And
7 so the idea of just focusing on cost measures
8 and endorsing cost measures made people very
9 uncomfortable.

10 The challenge that we had was we
11 didn't really know operationally if we were to
12 look at cost and quality measures together
13 like, what are we asking for, what are we
14 asking developers for, how would we guide our
15 committees to evaluate that, what are we
16 endorsing.

17 And so without that work we were
18 kind of sticking to what we knew around
19 endorsement for the cost measures in hoping
20 for an opportunity to really explore that
21 issue.

22 So the fourth row down, the RWJF

1 project around linking cause and quality
2 measures is really aimed at that. It's a
3 piece of work we've been wanting to do for
4 some time, to really explore what are some of
5 the mythological challenges to combining cost
6 and quality measures, what should we be
7 thinking about as NQF as an organization if
8 we're looking to eventually endorse efficiency
9 measures or how does that fit into value.

10 And so we actually met last week
11 actually, it seems like a lifetime ago. Last
12 week we convened a group of experts here to
13 talk about that. And it was a really
14 interesting discussion.

15 We are commissioning a white paper
16 with two authors, Chris Tompkins from Brandeis
17 and Andy Ryan from Cornell or Weill Cornell
18 thank you, to help us write that paper.

19 And they developed a draft paper
20 for the committee to review and then we had
21 the meeting, the two day meeting, to really
22 discuss the foundational paper and figure out

1 how we're going to build upon that. And so
2 that paper should be out hopefully in the next
3 month or so with some recommendations on where
4 we go from here with that.

5 You know, what is NQF going to be
6 looking to do around efficiency and value
7 measurement and where do we go in terms of
8 endorsement in that space and what we
9 potentially will be asking the development
10 community and others to do with going further
11 in that space.

12 In terms of implications for that
13 work we're hoping that that will give our
14 steering committees who are evaluating cost
15 and resource use measures some further
16 guidance on what to do as we continue to
17 accept cost measures and should that be
18 evaluated in the context of quality measures.

19 But also guidance potentially for
20 some of the MAP work around how to, what are
21 some considerations that should be included in
22 the discussions around selecting measures for

1 particular programs that are looking at
2 efficiency.

3 So hospital value-based purchasing
4 another programs. What should the committee
5 be thinking about when they're picking quality
6 measures and cost measures to make
7 recommendations for those programs.

8 In terms, should I keep going or -
9 -

10 (Off microphone comment.)

11 MS. MORESELL: Okay, I'll just
12 quickly touch on the episode grouper work and
13 how it kind of relates to some of the other
14 things and then I'll hand it back over and
15 take any questions if people have them.

16 We are continuing to do work
17 around cost and resource use measure
18 endorsement. We'll be meeting with our
19 committee in June and hoping that some of the
20 work from the linking cost and quality, from
21 that paper will be ready for us to kind of
22 feed back into that committee and see where we

1 go from there with this ongoing work as we
2 have a standing committee.

3 In terms of the episode grouper
4 evaluation criteria work, that work was really
5 initiated from some legislation that came out
6 awhile back around a public episode grouper
7 that was legislated by the secretary for her
8 to develop.

9 There was also language about a
10 consensus body evaluating or endorsing that
11 grouper and so our radars went up of course
12 and we're like, oh gosh, we've never evaluated
13 or endorsed an episode grouper, what does that
14 mean, what is an episode grouper, what are we
15 saying that we might potentially be endorsing.

16 And so this work was really to
17 help us do some foundational work in thinking
18 through, what do mean when we say episode
19 grouper. And it think David was on that
20 committee as well.

21 And so we, we're really trying to
22 figure out definitionally, what do we mean,

1 how does this relate to other measurement
2 systems. If we were to evaluate a grouper
3 what exactly will we be evaluating, what
4 criteria would we use, what will be endorsing.

5 And also to help us think through
6 operationally for NQF. Like what are some
7 things we need to be thinking about in terms
8 of our process.

9 For those of you that are familiar
10 with episode groupers they tend to have lots
11 and lots of measures within them and they are
12 very complex. And so that has a lot of
13 implications potentially for how we do our
14 work and what we would actually be evaluating
15 if that were to be submitted to NQF.

16 So that's kind of where we are and
17 happy to take any questions or --

18 MR. SAUNDERS: Sure.

19 MS. MORESELL: -- Rob, if you have
20 anything to add.

21 MR. SAUNDERS: Why don't I jump in
22 on the measure and affordability from the

1 patient's point of view and then will just --

2 MS. MORESELL: Sure.

3 MR. SAUNDERS: -- tag team from
4 there?

5 MS. MORESELL: Sure.

6 MR. SAUNDERS: And so one of the
7 last ones I just wanted to touch on was, and
8 in addition to this link and cost and quality
9 work, which we also did as sort of a parallel
10 project looking at how to measure
11 affordability from the patient's perspective,
12 and we did that about a month ago.

13 And the goal was to really think
14 about, very deeply, how do patients view
15 affordability. And I think differently than
16 some of our other meetings, we made sure that
17 there were actual patients at the table.

18 In fact that there were how many
19 six, you know, actual patients who came from
20 outside of the D.C. proffer area to really
21 think through this issue. Along with some of
22 the more standard folks that we have around

1 this table, like clinicians and hospitals and
2 insurance claims and the like.

3 And I think that was a useful
4 meeting and can help inform some of this group
5 just from a conceptual point of view because
6 what we heard from the patients were that
7 affordability didn't exist in a vacuum.

8 So yes, people looked at their out
9 of pocket cost and that was, they had a
10 number, they looked out of pocket cost divided
11 by income and that was affordability.

12 But then they also factored in
13 things such as, how inconvenient was my care.
14 Did it involve having to miss work multiple
15 times, because that work equals money. And
16 how does this affect my family. How does this
17 affect my quality of life. And that those
18 issues sort of came to a broader perspective
19 of affordability which I think were many of
20 the themes that were brought up in this group
21 over the last two days.

22 And so the reason we wanted to

1 make sure we highlighted these four other
2 projects was that this group has been thinking
3 about how to implement the MAP affordability
4 family.

5 And we thought some of this work
6 may be useful for, as this group starts to
7 think through, how would this family be used
8 in practice and where can we leverage what
9 we've learned from these other NQF projects
10 like say linking cost and quality, which was
11 a theme that came up yesterday in I think all
12 three breakout groups, into how we might use
13 this family in practice.

14 So I guess, and now if folks have
15 questions or comments or thoughts?

16 DR. MCCLELLAN: Yes any comments?
17 I mean clearly these projects overlap with
18 some of the next steps, especially measurement
19 gaps, that we've proposed, you know, most
20 recently in some of the measures in the last
21 session on patient reported views about
22 affordability of care. Kevin?

1 DR. LARSEN: Any ETA on the
2 episode groupers, like when those are coming
3 and when we could think about those being part
4 of some measurement framework? Because
5 they're appealing to put, as bands around cost
6 and quality.

7 DR. MCCLELLAN: Well that's not
8 the, this is not an actual evaluation grouper
9 this is the criteria. But there's a lot of
10 work, I mean there are a lot of measures that
11 have been submitted already that relate to ETA
12 groups and all that.

13 MS. MORESELL: Yes. So our last
14 conversation with CMS, and obviously this has
15 kind of been an anxiety producing issue for us
16 as well.

17 Our last conversation, it's not
18 that close actually. There's a lot of
19 measures still in development. Probably a
20 year or two off. I think there was some
21 anticipation that it might come sooner, but I
22 think now as their kind of getting into the

1 development of some of the additional
2 condition-specific episodes that it's probably
3 going to be at least a year.

4 DR. LARSEN: And just one of the,
5 you know, word of caution from the trenches of
6 the details, it's really easy to think at the
7 description level that you're describing the
8 same episode and then when you actual dive way
9 down deep and realize that one measure was
10 developed by NCQA and one by the Joint
11 Commission and another one by the State of
12 Minnesota, they actually have fairly different
13 definitions of the orthopedic episode of care
14 even though they say they're all talking about
15 the same definition.

16 So we've been trying to find
17 informatics ways to really be sure the
18 specifications around things like denominators
19 are as similar as possible. And that would be
20 one of the things that we'd really highly
21 recommend as we do this, that we're really, we
22 work hard to leverage some consistent

1 definitions across a suite of related measures
2 so they really are, the same people are in all
3 the measures when we actually get to the end.

4 DR. MCCLELLAN: Nancy?

5 MS. FOSTER: Sorry, I'm just
6 chuckling at the thought that same title of
7 measures might be different. How unusual.

8 DR. MCCLELLAN: Yes.

9 MS. FOSTER: But what I was going
10 to say really actually came from your comments
11 and, Rob, your comments about the other
12 organization, or the other groups works.

13 In particularly the work being
14 done around affordability for the patients.
15 Really terrific that you were able to bring in
16 some real live patients to talk about their
17 perceptions of it and I look forward to seeing
18 that report because it will inform all of us.

19 But we sort of talked as if we
20 were focusing on affordability to the patient.
21 And I think in our hearts and minds that was
22 the right place to go.

1 But as we went through things
2 during the conversation I think we also
3 touched on affordability at a wide variety of
4 levels. As a nation, as a, you know, the
5 payor, the employer, groups.

6 And so maybe there's a way to
7 tease out in our report that we really need
8 affordability at all of those levels and we
9 need to be able to judge it at all of those
10 levels. Which may be done by using similar
11 measures or some of the same measures.

12 But there may also be other tools
13 that are available to judge affordability at
14 a national level like, you know, percent of
15 GDP that aren't really relevant to the
16 individual patient.

17 DR. MCCLELLAN: Thanks. You
18 disagree, David, right? Yes, thanks.

19 All right, Ashley, thanks for the
20 discussion and Rob. Thank you all for all the
21 hard and challenging work going on to get us
22 where we need to be. So now we can be even

1 more bold in our recommendations, right, about
2 what needs to be, what needs to come forward.
3 Thank you.

4 So our last kind of substantive
5 discussion section is on conceptual guidance
6 for applying the affordability family in
7 practice. We're ready to move onto that?

8 MR. SAUNDERS: Sure, yes.

9 DR. MCCLELLAN: There are a few
10 more slides with details of what we've just
11 discussed, yes.

12 I don't think that's, so this is,
13 you know, as we've just talked about and been
14 talking about over the last couple of days,
15 there are some real challenges. Not just in
16 the measures, but in using these measures
17 effectively to help improve decisions by
18 individuals, by payers and purchasers, by
19 policy makers.

20 And one of the things that we
21 wanted to do to help wrap up the report is
22 make sure we're highlighting important

1 considerations that we think need to be
2 addressed in conjunction with using the
3 affordability measures today and the improved
4 affordability measures in the future that are
5 the main subject of this report.

6 So in terms of these kinds of
7 quality recommendations, we're not the first
8 to go here, the NQF has previously
9 highlighted, you know, most people here
10 generally agree that it's not about cost or
11 affordability measures by themselves but the
12 cost and quality measures need to be aligned
13 to truly understand value.

14 It also came up in the HFMA report
15 that may be referenced over the last couple of
16 days. And NQF is already clearly on record as
17 supporting the use and reporting of resource
18 use, cost and other measures in the context of
19 quality performance measures. Preferably
20 outcome measures.

21 And just looking at resource use
22 measures alone doesn't provide an accurate

1 assessment of efficiency or value and can have
2 undesirable consequences. This was also
3 discussed recently at the Medpac meeting.

4 I think Rob you may touch, you
5 want to touch on some of these issues as well.
6 So this is just for context to put in place
7 that there already is a lot of thinking and
8 NQF related statements out there about how to
9 use affordability types of measures. But I
10 want to make sure this group has a chance to
11 see if there's anything they want to add to
12 that or particularly highlight.

13 MR. SAUNDERS: And I think, again,
14 this group has already done some great work
15 thinking about that. Especially in
16 yesterday's breakout groups that it was
17 interesting that each of the three
18 independently came up with conceptual guidance
19 about implementation and that helps the staff
20 because now we can start to see some consensus
21 that naturally emerged.

22 One of the things that came up and

1 we wanted to at least flag was there's an idea
2 of balancing measures as well. And that's
3 been brought up by Medpac about the idea of
4 that many cost affordability measures are
5 focused on overuse. And there maybe a need
6 for balancing measures looking at under-use to
7 make sure that we're sort of furnishing that
8 middle ground.

9 And so we just wanted to make sure
10 we at least highlighted that concept.
11 Although that's not necessarily the only
12 concept that this group may want to think
13 about or bring up in talking about conceptual
14 guidance for implementation.

15 Clearly these issues about linking
16 costs and quality is something that's come up
17 a lot and that ties into some of the other NQF
18 work that's been done out there. But we
19 wanted to make sure we brought up this Medpac
20 work as well.

21 DR. MCCLELLAN: Great, so I see
22 some cards up already so, Kevin, start with

1 you.

2 DR. LARSEN: So that, I think to
3 add to the balancing, we've talked a lot about
4 making sure the quality is a balancing
5 measure.

6 The other word of caution I'll
7 make, and this is from experience of doing
8 kind of block grant capitation, is there is a
9 certain brittleness to relaying on claims to
10 measure efficiency. So what we found is that
11 we were able to gain a lot of efficiencies in
12 outcomes but that it was really hard to
13 measure using claims when we did all sorts of
14 new things.

15 So examples. When we could use
16 care coordinators or community health workers
17 that don't generate a claim. When we can do
18 telephone calls instead of visits. When we
19 can do emails instead of telephone calls or ER
20 or ambulance runs.

21 There was a ton of efficiencies
22 that we could build into the system. But a

1 claimed-based efficiency measurement couldn't
2 see any of it. It just looked like there was
3 no care.

4 And so I don't know exactly how to
5 say that other than a word of caution and be
6 really sensitive to the fact that relying on
7 claims as the primary way to do this will not
8 necessarily get us the results we want.

9 DR. MCCLELLAN: Thanks. And
10 Davids, I'm not sure which one went up first.

11 DR. SEIDENWURM: The balance
12 between overuse and underuse measures, there
13 are some circumstances where we can define an
14 appropriate rate of something, and so that can
15 be combined in one metric, you know, as a
16 range. And we've been discouraging people
17 from doing that in the past because I think of
18 the logistics of making the measurement and
19 the purposes for which they can be applied.

20 But I think maybe as some of the
21 data processing becomes more sophisticated and
22 our knowledge improves, perhaps we can have

1 metrics that define appropriate ranges rather
2 than just, you know, below this or above that.

3 MS. HASKELL: That sounds pretty
4 scary. I'm thinking of things like
5 appropriate range of C-section. I don't know,
6 it just sounds scary.

7 DR. SEIDENWURM: Well, okay. I
8 mean maybe that's, you know, I don't know the
9 exact numbers for that. There are areas where
10 I do know numbers. But, you know, you don't
11 want the rate to be zero, right, but you don't
12 want it to be 50 percent either, and I think
13 there must be, you know, some optimum range.

14 Just like for cardiac surgery, I
15 mean you want the rate to become low, but a
16 zero rate would mean that you may be you know,
17 weren't operating on some people that you
18 could really help. Or maybe if a mammographer
19 wanted to pass a recall rate that had a
20 ceiling, then they would just, you know, call
21 them all normal like the guy that just pleaded
22 guilty in, was it southern California.

1 So I think a range may be, when we
2 have the knowledge might be the way to go.

3 MS. HASKELL: I just think that
4 would depend so much on provider skill. I
5 mean again using C-sections that there would
6 be providers who were capable of avoiding many
7 more C-sections than some others.

8 DR. MCCLELLAN: David?

9 DR. HOPKINS: I was going to make
10 a suggestion on framing this balance concept.
11 It really popped out at me on the previous
12 slide. Can we maybe have that back? Thank
13 you, Mark.

14 DR. MCCLELLAN: This one?

15 DR. HOPKINS: Yes. So this is the
16 traditional way of thinking is we spent all
17 these years gathering data on quality and
18 finally we've got some pretty good measures of
19 quality but we're sure not all the way there
20 yet. And now we're starting to come back to
21 costs, and we're saying don't do cost without
22 quality. Why isn't this a two-sided

1 recommendation?

2 We're in an era where the focus is
3 or should be on value, so why isn't it, don't
4 measure quality without cost and don't measure
5 cost without quality? Two-sided. So I'd like
6 to make that proposal for amendment.

7 And, you know, even on the next
8 slide where it talks about balance, overuse,
9 underuse, again we want to put equal weight on
10 both.

11 DR. MCCLELLAN: Okay, with that
12 any thoughts?

13 MS. FOSTER: I mean, seriously, it
14 makes me nervous when we think about issues
15 where you wouldn't do something that the
16 patient could benefit from because of the
17 cost.

18 DR. MCCLELLAN: I don't think that
19 David was saying not do it, he was just
20 saying, you know, have a measure so that
21 you're aware of the cost implications.

22 DR. HOPKINS: We're talking about

1 these global measures of performance, right?
2 Cost, quality, let's do them both.

3 DR. MCCLELLAN: Sean?

4 MS. FOSTER: Thank you.

5 DR. ADAMS: It was scary not only
6 to you and Helen, but also to Congress when
7 they didn't let comparative effectiveness
8 research take cost into account. I don't know
9 whether that straps us, but there is clearly
10 a political view out there that it's a one-
11 sided argument.

12 DR. MCCLELLAN: Don?

13 MR. MAY: Yes, I would agree about
14 the concern of going too far, and I think
15 watching that's going to be important. You
16 know, I think in particular in a world where
17 we're now moving into, you know, we've had
18 health plans and payers being the check on
19 physicians and providers, and actually I think
20 patients wanting things.

21 So you've had that natural check
22 and balance of the user versus the payer, and

1 the payer saying, you know, let's slow down,
2 we're not going to cover this or we're going
3 to pay less for this to provide incentives for
4 use.

5 I think as we see providers now
6 taking on more risk, the importance of,
7 especially from the affordability context,
8 when they're thinking about cost maybe as much
9 as they're thinking about service, we do need
10 to think about appropriate measures that start
11 to look at underuse.

12 And I think whether there's
13 stinting or whether there's delaying care, and
14 because as we're learning what these episodes
15 are, you know, what is efficient in a 30-day
16 period may be inefficient in a 90-day period
17 or a year.

18 And so I think developing -- and
19 we've been trying to think a lot about what
20 these measures might be, and having trouble so
21 I'm actually very interested in looking at
22 these.

1 But I think it's really important,
2 especially as we have providers now going into
3 more risk-based models where they're thinking
4 much more about costs than they have in the
5 past.

6 DR. MCCLELLAN: Any other
7 thoughts? Sounds like a good opportunity for
8 some thoughtful writing to capture the right
9 balance and tone here.

10 DR. LARSEN: And I think that's
11 where these episodes become really, really
12 helpful, because then you can box this
13 conversation into something where you can
14 imagine a balancing measure of outcome, cost,
15 underutilization.

16 I mean everything is just sort of
17 squishy overlaps of possible squishy concepts
18 and time intervals and people responsible.
19 It's pretty hard to know that what you're
20 changing in, you know, this half of a Venn
21 diagram is the thing that actually changed
22 that half of the Venn diagram when they only

1 have 20 percent overlap.

2 So having much tighter overlap,
3 then I would be more confident about the two
4 having a tight relationship.

5 DR. MCCLELLAN: Thanks. Sean?

6 DR. ADAMS: So as you're writing
7 this report, what is the length between these,
8 potentially these recommended and potentially
9 implementable measures and the value-based
10 purchasing program?

11 DR. MCCLELLAN: I don't think
12 there's a direct link. I mean this report is
13 about the measurement issues and there are a
14 whole host of issues around linking measures
15 into payment.

16 That said, if there is some sort
17 of general guidance or thoughts that we want
18 to include about how these measures would be
19 implemented and used, I mean this would be the
20 place to do it.

21 So, for example, this discussion
22 we've just been having especially about as

1 providers are moving into more risk-based
2 payment systems, it's important to include
3 along with the measures of affordability or
4 efficiency, some measures of potential
5 underuse, you know, that would be kind of a
6 general guidance principle, something like
7 that.

8 Rob, do you want to add or
9 clarify?

10 MR. SAUNDERS: No, I think that
11 covers it. I think it hits the point of what
12 the application in this family will be. And
13 one of the hopes is that by creating this
14 affordability family that's a pre-screened
15 family that when it comes time to do pre-
16 rulemaking and as they talk about value-based
17 purchasing measures that then the MAP at that
18 time can turn to this list and use that as an
19 opportunity to move things along.

20 But it doesn't necessarily affect
21 the program directly unless this group would
22 like to make a particular description about

1 that.

2 DR. ADAMS: Well, the thing that
3 strikes fear in the hearts of the providers,
4 and I'll speak from that perspective, is that
5 we have seen most attempts to measure quality
6 and service turn into value-based purchasing
7 entities. So we'll divide your HCAHPS with
8 the five-year infection rates and we'll divide
9 it into tertiles and do a reward-punish thing
10 on that.

11 So the squishier and the greater
12 number of these blunt elements come, the more
13 you get this sort of tapestry of what quality
14 is. And the fear for the providers would be
15 that someone will pick and choose and start
16 dividing any of those metrics into quintiles.

17 So we would want to encourage --

18 DR. MCCLELLAN: So this sounds
19 like a different concern than sort of these
20 balancing concerns, overuse, underuse, and
21 cost and quality measures together that we've
22 already talked about. This is about turning

1 measures that may not have been created for,
2 say, ranking purposes into rank measures or
3 something like that.

4 DR. ADAMS: Yes, so that has been
5 the momentum on all the other ones, so we
6 don't have any real reason to think this would
7 be automatically immune unless we choose to
8 state that early in the game.

9 DR. MCCLELLAN: I'm just trying to
10 think of the best way to capture that.
11 Because we do want to go forward with our
12 measure recommendations, sort of caution about
13 using them in areas where they haven't been
14 tested or validated like for ranking purposes.

15 DR. ADAMS: Well, we would say
16 something like, used in conglomeration they
17 paint a picture of outliers or places to ask
18 questions, is it too much here or is too
19 little, but that taken individually they have,
20 say, this nicer little value taken in as an
21 individual metric.

22 DR. MCCLELLAN: Okay. I think

1 that kind of fits with the other themes. And
2 this would be a good place to look at the --

3 DR. ADAMS: Right. So, you know,
4 for example, the infection ones which are kind
5 of easy. I mean those are imminently going to
6 be paid by where you buy in those HII, HCAHPS
7 same way. But they're pretty tangible, pretty
8 reasonably tangible. But a lot of things that
9 we have been talking about are not under the
10 purview necessarily, or the person who they're
11 attributable to. And so we have to be careful
12 of whether we overstate that connection.

13 DR. MCCLELLAN: Kevin?

14 DR. LARSEN: Just a related idea
15 we were talking about over lunch is that there
16 is a tension between system measures and
17 individual measures, and those could be
18 individual to providers, individuals to
19 hospitals, individuals to whoever as a sort of
20 single entity.

21 And we often talk about these like
22 they'll be easily applied in the same way

1 across all of those spaces, and it doesn't
2 really work very well that way, to Sean's
3 point.

4 That you can attribute to Kaiser a
5 certain set of Care Coordination activities,
6 but then we heard testimony from some of the
7 Medicare Shared Savings independent practices
8 that primary care doctors had direct control
9 over five percent of the total Medicare spend
10 for the Shared Savings Program that they were
11 accountable for.

12 And so they had signed up and
13 they're still going to do it, but the thing to
14 realize is that's a really different lever
15 than the lever that Kaiser has as an
16 integrated health system with the health plan.

17 DR. MCCLELLAN: And in addition to
18 that, measures that can even be calculated
19 accurately and reliably for one level of
20 providers can't be done at more microlevels
21 too.

22 Okay, any other thoughts about the

1 report? And again there will be a chance
2 to comment on this when the draft comes around
3 too.

4 Jim?

5 DR. DUNFORD: Just taking that
6 even back up to the population level, I think
7 that the report has to send out and make the
8 statement which is already obvious, which is
9 that 80 percent of the determinant's health
10 care costs are social determinants.

11 They're really, like you say,
12 outside of the control of even a plan or a
13 physician. That the attention really,
14 ultimately, has to be directed upstream to the
15 population based metrics and the integration
16 across non-health services that are actually
17 also we can share in.

18 I mean there are great savings to
19 be had by better care coordination, for
20 example, of mental health in the jails. And
21 so there are enormous economies that we can
22 have if we start looking toward nontraditional

1 partners.

2 And I think that the future will
3 be to incorporate more people outside the box
4 to come in here who are stakeholders in the
5 final cost equation of this whole thing than,
6 you know, assembling us who are health
7 providers, because to a certain extent this is
8 out of our control.

9 DR. DUNFORD: But possibly within
10 in our control in nontraditional ways. I mean
11 if you give someone an apartment, you know, a
12 homeless person an apartment, their health
13 care spending goes down and things like that.
14 So it may be aspirationally something we could
15 touch on.

16 DR. MCCLELLAN: Moving beyond the
17 traditional scope of health care providers as
18 you're doing in San Diego.

19 Any other final comments? Like I
20 said, we are going to finish on time. I would
21 like to turn now to the operator. Operator,
22 can you check to see if there are any public

1 comments?

2 OPERATOR: If you would like to
3 make a comment, please press star then the
4 number 1. There are no public comments at
5 this time.

6 DR. MCCLELLAN: Okay, thanks very
7 much, operator.

8 Now the last item here is list a
9 summary of Day 2 and next steps, and we've
10 been trying to summarize as we've been going
11 along so I'm not going to try to do a detailed
12 recap now.

13 I would like to turn to Rob to
14 talk about, Rob and team, to talk about what's
15 next from here and then maybe spend a few
16 minutes if there are any questions about that
17 or anything else that you'd like to make sure
18 we do summarize or at least get on the table
19 before we move forward with the rest of this
20 process.

21 MR. SAUNDERS: Sure. And I'll
22 talk sort of broad conceptually and I'll ask

1 my colleague Erin to help me with some of the
2 timeline dates as well.

3 But from here the staff will go
4 back and we're going to huddle up in the next
5 few days to analyze our notes and make sure
6 we're pulling out the broad themes that have
7 come out here. We're also collaborating with
8 the other two families as we're putting out
9 this report together on putting out a joint
10 product, and we'll certainly work with them
11 and share with them what we've talked about in
12 these few days and also make sure that we can
13 benefit from what they've learned.

14 And then this report will go out
15 for public comment and then we will eventually
16 have a final report relatively quickly.

17 Erin, would you mind talking
18 through what the timeline is for those steps
19 now? Just sort of when are we going to have
20 a report ready for public comment and when do
21 we need to have this done?

22 MS. O'ROURKE: We're hoping to

1 have the report available for public comment
2 June 2nd. We don't think we'd be able to get
3 the task force an advanced copy, but if you
4 have comments on that we can incorporate your
5 comments at the same time as the public
6 comments and bring that to the coordinating
7 committee, I believe, the week of June 20th to
8 turn the report into HHS July 1.

9 MR. SAUNDERS: So with a
10 relatively short turn around in all these
11 steps. But we want to make sure that we hear
12 from you and we'll make sure we keep you
13 informed as public comment happens and as we
14 move to the coordinating committee as well.

15 MS. FOSTER: Rob, I'm not sure I
16 understood. Is it one report for all three of
17 the groups?

18 MR. SAUNDERS: That's right.

19 DR. MCCLELLAN: Do you want to say
20 a little bit more about how that all is going
21 to come together or maybe you're working on
22 that now.

1 MR. SAUNDERS: So there's some
2 magic. And the hope would be that each of
3 three families are putting together a short
4 brief about their particular family, so a few
5 pages, and then we'll draw at key themes that
6 seem to stay in the families.

7 And as we've discovered today
8 there are some key themes that seem to cross
9 lines, and especially in terms of gaps but
10 also in terms of just where the task forces
11 would like the field to go, and there's some
12 clear sort of opportunities that overlap.

13 So that's the hope although we
14 hope that we'll have a product that we can
15 pull out to show here's what the affordability
16 family looks like, and be able to share that
17 more particularly with others but to have an
18 integrated product that we need to turn in to
19 HHS.

20 DR. MCCLELLAN: Other questions or
21 comments? All right. So please do look for
22 that report coming. Sounds like June 2nd is

1 a firm date.

2 MS. O'ROURKE: Should be fairly
3 firm. I think that's as late as it can go.

4 DR. MCCLELLAN: And there's been a
5 very rich discussion. They're all very
6 challenging issues but they're critical ones,
7 and I appreciate a lot of different
8 perspectives around the table. I appreciate
9 how constructive everybody was in trying to
10 find an effective path forward for
11 recommendations.

12 I'm sure the NQF staff is going to
13 do the best job they can in trying to capture
14 all of this, but if you see the report on the
15 2nd and it doesn't capture everything
16 perfectly just keep in mind there is still
17 time to revise and make sure any critical
18 issues do get addressed, and I'll be available
19 along with Rob for any follow-up on major
20 questions you might have.

21 In the meantime, I think there are
22 a few issues where staff may want to get back

1 to you about specific measures that you
2 referenced or projects or evidence related to
3 points that are important for the report, so
4 thanks in advance for being available for that
5 as well.

6 And mostly thanks for all the time
7 and effort on this issue, both all of you who
8 are members of this committee and especially
9 the NQF staff who I know have had to put in a
10 ton of time already putting this together, and
11 I don't envy your next few weeks either. So
12 thank you all very much.

13 (Applause.)

14 DR. HOPKINS: And thanks to our
15 chair.

16 (Whereupon, the meeting in the
17 above-entitled matter was concluded at 2:10
18 p.m.)
19
20
21
22

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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.



Court Reporter

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